STATE OF TENNESSEE

DEPARTMENT OF COMMERCE AND INSURANCE

TENNCARE DIVISION

MARKET CONDUCT EXAMINATION

and

LIMITED SCOPE FINANCIAL AND COMPLIANCE EXAMINATION

OF

UAHC HEALTH PLAN OF TENNESSEE, INC.
(formerly known as OmniCare Health Plan, Inc.)

MEMPHIS, TENNESSEE

FOR THE PERIOD JANUARY 1, 2004
THROUGH DECEMBER 31, 2004

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DATE: May 15, 2006

The examination fieldwork for a Limited Scope Financial and Compliance Examination and Claims Processing Market Conduct Examination of UAHC Health Plan Of Tennessee, Inc. (UAHC), Memphis, Tennessee, was completed November 15, 2005. The report of this examination is herein respectfully submitted.

I. FOREWORD

On April 20, 2005, TennCare Division of the Tennessee Department of Commerce and Insurance (TDCI) issued a notification of administration supervision because TDCI determined UAHC to be in a hazardous condition based upon the apparent untrustworthiness of UAHC management of possible violations of the conflict of interest provisions of the Contractor Risk Agreement (CRA). Additionally, TDCI initiated an examination of the books and records of UAHC. During administrative supervision management retains control of the operations but certain transactions require prior approval by the Commissioner or her designated representative. The notice of administrative supervision expired on December 31, 2005.

This report reflects the results of a market conduct examination "by test" of the claims processing system of UAHC. Further, this report reflects the results of a limited scope examination of financial statement account balances as reported by UAHC. This report also reflects the results of a compliance examination of UAHC's policies and procedures regarding statutory and contractual requirements. A description of the specific tests applied is set forth in the body of this report and the results of those tests are included herein.

II. PURPOSE AND SCOPE

A. Authority

This examination of UAHC was conducted by TDCI under the authority of Section 3-6. of the CRA between the State of Tennessee and UAHC, Executive Order No. 1 dated January 26, 1995, and Tennessee Code Annotated (Tenn. Code Ann.) § 56-32-215 and § 56-32-232.

UAHC is licensed as a health maintenance organization (HMO) in the state and participates by contract with the state as a managed care organization (MCO) in the TennCare Program. The TennCare Program is administered by the TennCare Bureau within the Tennessee Department of Finance and Administration.

B. Areas Examined and Period Covered

The market conduct examination focused on the claims processing functions and performance of UAHC. The testing included an examination of internal controls surrounding claims adjudication, claims processing system data integrity, notification of claims disposition to providers, and payments to providers.

The limited scope financial examination focused on selected balance sheet accounts and the TennCare income statement as reported by UAHC on its National Association of Insurance Commissioners (NAIC) annual statement for the period ended December 31, 2004, and the Medical Fund Target Report filed by UAHC as of December 31, 2004.

The examination period was expanded through the performance of a medical claims overpayment review of all claims paid during the no risk period for dates of service May 1, 2002, through June 30, 2005. The separate medical claims overpayment review is included as an appendix to this report.

The limited scope compliance examination focused on UAHC's provider appeals procedures, provider agreements and subcontracts, the demonstration of compliance with non-discrimination reporting requirements and the Insurance Holding Company Act.

Fieldwork was performed using records provided by UAHC before and during the onsite examination. Site visits to the Memphis office were conducted periodically from April 25, 2005 through November 15, 2005.

C. Purpose and Objective

The purpose of the examination was to obtain reasonable assurance that UAHC's TennCare operations were administered in accordance with the CRA and state statutes and regulations concerning HMO operations, thus reasonably assuring that the UAHC TennCare enrollees received uninterrupted delivery of health care services on an ongoing basis.

The objectives of the examination were to:

- Determine whether UAHC met certain contractual obligations under the CRA and whether UAHC was in compliance with the regulatory requirements for HMOs set forth in Tenn. Code Ann. §§ 56-32-201 *et seq*.;

- Determine whether UAHC had sufficient financial capital and surplus to ensure the uninterrupted delivery of health care services for its TennCare members on an ongoing basis;

- Determine whether UAHC properly adjudicated claims from service providers and made payments to providers in a timely manner;

- Determine whether UAHC had implemented an appeal system to reasonably resolve appeals from TennCare providers in a timely manner; and

- Determine whether UAHC had corrected deficiencies outlined in prior reviews of UAHC conducted by TDCI and the Comptroller of the Treasury (Comptroller).

III. PROFILE

A. Administrative Organization

UAHC, formerly OmniCare Health Plan, Inc., was chartered in the State of Tennessee on October 6, 1993, for the purpose of providing managed health care

services to individuals participating in the State's TennCare Program. UAHC is a wholly owned subsidiary of United American of Tennessee, Inc. (United American Tennessee) which is a wholly owned subsidiary of United American Healthcare Corp. (United American Detroit). On April 21, 2005, OmniCare Health Plan, Inc., requested modification to its Certificate of Authority (COA) to reflect the new corporate name UAHC Health Plan of Tennessee, Inc. On April 25, 2005, TDCI granted this modification with an effective date of March 21, 2005. UAHC contracts with United American of Tennessee, Inc. (United American Tennessee) to provide management services.

The officers and board of directors for UAHC at December 31, 2004, were as follows:

Officers for UAHC

Osbie Howard , Chief Executive Officer
Lorenzo Harris, Chief Financial Officer
Dorothy Brewer, Assistant Secretary
Edward W. Reed, M.D., Senior Vice-President & Medical Director
Stephanie Dowell, Senior Vice-President & COO
Edward Dixon, Vice-President Corporate Compliance
Stacy Hill, Vice-President MIS
Myla Johnson, Vice-President Medical Services

Board of Directors for UAHC

Alvin King	Julius V. Combs, M.D.
Rebecca Clark	Samuel King
William C.Brooks	Frank Banks
Beverly Williams-Cleaves, M.D.	Charles Carpenter
Stephen D. Harris	Tom Gross
Griselle Figueredo, M.D.	

Board of Directors for United American Detroit

William C. Brooks	Stephen D. Harris
Darrel W. Francis	Richard M. Brown, D.O.
Tom A. Goss	Ronald E. Hall, Sr.
Emmett S. Motten Jr.	Peter F. Hurst, Jr.
Osbie Howard	

B. Brief Overview

Effective July 1, 2002, the CRA with UAHC was amended to temporarily operate under a no risk agreement from July 1, 2002, through December 31, 2004. This period, otherwise known as the "stabilization period," was established to allow all MCO's a satisfactory period of time to establish financial stability, maintain continuity

of a managed care environment for enrollees and assist the TennCare Bureau in restructuring the program design to better serve Tennesseans adequately and responsibly. UAHC agreed to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures as they existed April 16, 2002, unless such a change received approval in advance by the TennCare Bureau.

During September 2002, UAHC's actuary certified that UAHC would require $7,500,000 in order to meet its statutory net worth requirements for the period ending June 30, 2002. Amendment Number 3 to the CRA between UAHC and the TennCare Bureau executed September 25, 2002 expanded the no risk period and other contract terms as follows:

1. Effective July 1, 2001 through April 30, 2002, UAHC elected to operate under Option 2 as described in Section 3-10.e.2. of the Amended and Restated CRA. The risk sharing varies dependent upon the percentage above the medical loss ratio (MLR). UAHC is responsible for the first two percent (2%) of medical costs, regardless of profits or loss, beyond the minimum 85% MLR. The State will pay for 50% of additional medical costs between 87% to 97% MLR. Above a 97% MLR the State will pay the following percentage of medical costs:

    - July 1, 2001 through December 31, 2001 90%
    - January 1, 2002 through April 30, 2002 80%

2. Effective May 1, 2002 through June 30, 2002, UAHC was to be reimbursed on a no risk basis for medical services.

3. It was expressly agreed that the maximum amount paid would not exceed $7,500,000. Should the actual amount required to reinstate UAHC's net worth be less than $7,500,000, UAHC and TennCare agreed that the payment under this amendment would be reduced to meet the amount necessary.

4. It was expressly understood by both parties that the funds identified herein could not be used for administrative purposes including management fees and UAHC had to remain operating and doing business in Tennessee for payment of its contractual obligations with providers in the State of Tennessee.

On October 4, 2002, the TennCare Bureau and UAHC entered into a memorandum of understanding which stated, "It is the intent of the State to amend the OmniCare Contractor Risk Agreement should certified actuarial data confirm that additional funds are needed beyond the $7,500,000 provided in Amendment Number 3 to the Contractor Risk Agreement. OmniCare will provide all actuarial or other data requested by the State for review and analysis. The data to be reviewed is for the period July 1, 2001 through June 30, 2002."

During stabilization, UAHC receives from the TennCare Bureau a monthly fixed administrative payments based upon the number of TennCare enrollees assigned to UAHC. The TennCare Bureau reimburses UAHC for the cost of providing covered services to TennCare enrollees.

UAHC is currently authorized by TDCI and the TennCare Bureau to operate in the community service areas of Shelby County, Northwest Tennessee and Southwest Tennessee which comprise the West Grand Region. All premium revenue earned by UAHC is from payments received for enrollees assigned by the TennCare Bureau. As of December 31, 2004, UAHC had approximately 130,000 TennCare members.

C. Claims Processing Not Performed by UAHC

TennCare has contracted with other organizations for the administration and claims processing of these types of services:

- Dental
- Pharmacy
- Behavioral Health

During the period under examination, UAHC subcontracted with the following vendors for the processing and payment of claims submitted by providers:

- Vestica HealthCare (formerly Doral USA) for medical claims processing
- Block Vision for vision claims processing

IV. PREVIOUS EXAMINATION FINDINGS

The previous examination findings are provided for informational purposes. The following were financial and claims processing deficiencies cited in the examination by TDCI and the Comptroller for the period January 1, 2003, through March 31, 2003.

A. Financial Deficiencies

1. UAHC did not submit for required approval by TDCI modifications to the management agreement between UAHC and its parent company United America of Tennessee, Inc., before the modifications were implemented.

2. UAHC incorrectly reported as an admitted asset receivables which exceeded 90 days old as of the sworn submission date on the March 31, 2003, NAIC Quarterly Financial Statements. The misstatement of the financial statements was the result of UAHC's failure to abide by the terms of Letter of Agreements with two medical providers. Subsequently, the receivables were collected which negated a required adjustment to net worth.

3. UAHC's claims unpaid as reported on the March 31, 2003, NAIC Quarterly

Financial Statement was understated by at least $318,279. The understatement of claims unpaid did not affect UAHC's net worth as of March 31, 2003.

4. UAHC's Supplemental TennCare Operations Statement for the three months ending March 31, 2003, was not prepared as if UAHC were still at risk by including all income and expenses related to claims, losses, and premiums for claims as required by section 2-10.i. of the CRA.

These findings are not repeated in this report.

B. Claims Processing Deficiencies

1. The following deficiencies were noted during the review of the claims payment accuracy report preparation procedures:

   - The Claims Payment Accuracy report prepared by UAHC's claims processing subcontractor was not verified by UAHC for accuracy.

   - Pharmacy claims processed by Scripts Pharmacy Solutions, Inc. and vision claims process by Block Vision were not included in the determination of the claims accuracy percentage.

   - Documentation was not maintained supporting the random selection of claims. As a result, the examiners could not verify that the claims tested were randomly selected as required in the section 2-9. of the CRA.

   - Documentation was not maintained supporting that the total claims population was defined before the claims tested were selected.

2. The procedure code reported on one claim tested did not agree with the procedure code entered in the claims system resulting in the incorrect reporting of encounter data to the TennCare Bureau and resulting in the incorrect payment of the claim.

3. Two claims on the second submission by the provider were incorrectly denied due to untimely filing. The claims were originally submitted within the 120 day timely filing limit. Subsequently, UAHC paid the claims based on provider appeals.

4. The fee table loaded in the claims processing system was incorrect for four claims tested resulting in incorrect payments to providers.

Findings 2 and 3 are not repeated in this report. Findings 1 and 4 are repeated in this report.

C. Compliance Deficiencies

1. As of the end of the examination fieldwork, UAHC contracted with five hospitals

through a "Letter of Agreement" versus the required provider contract templates approved by TDCI. The Letter of Agreement is deficient in 36 of the required 44 minimum contract language requirements of section 2-18. of the CRA. Operation by UAHC under the Letter of Agreement is in a manner contrary to information submitted to TDCI to obtain and maintain its certificate of authority to operate as a HMO. Subsequently on February 24, 2004, UAHC amended the "Letter of Agreement" to correct the deficiencies noted in the examination.

2. UAHC lacks an internal audit function as part of UAHC's organization structure.

3. UAHC needs to improve the monitoring efforts of its major subcontractor for claims processing services.

4. For the 20 provider complaints selected for testing, 13 (65%) were not responded to within 30 days after the receipt of the complaint per Tenn. Code Ann. § 56-32-226(b)(3)(A).

5. Two provider contracts selected for testing did not include all provisions required by section 2-18. of the CRA.

Findings 1, 2 and 5 are not repeated in this report. Findings 3 and 4 are repeated in this report.

V. SUMMARY OF CURRENT FINDINGS

The summary of current factual findings is set forth below. The details of testing as well as management's comments to each finding can be found in Sections VI, VII, and VIII of this examination report.

A. Financial Deficiencies

1. On December 20, 2004, the terms of the management agreement were not followed because United American Tennessee entered into a lease agreement with UAHC as the lessee. Operation by UAHC under the lease agreement was in a manner contrary to information submitted to TDCI to obtain and maintain its certificate of authority to operate as a HMO. The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operation documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1) (See Section VI.A.3).

2. UAHC should improve the methodology utilized for the allocation of management fees to NAIC expense categories by initially identifying salaries and compensation incurred by United American Tennessee which are 100% related to UAHC or other operations. Direct costs that are related 100% to specific operations should be allocated to the specific operations before other pertinent ratios are applied. (See Section VI.A.4.)

3. UAHC recovered third party liability and subrogation of $79,914 through August 17, 2005 that had been previously reimbursed by the State through Amendment 3 funding. As of the examination fieldwork date, UAHC had not remitted any of these amounts to the State. As third party liability and subrogation amounts are recovered from no risk funding, UAHC should reduce the next medical reimbursement request to the TennCare Bureau for the amounts recovered. An examination adjustment to net worth for $79,914 is required. (See Section VI.A.7.)

4. On the 2004 NAIC Annual financial statement, certificate of deposits of $3,605,000 were incorrectly reported as bonds. Certificates of deposits depending on a maturity date either less than one year or greater than one year should be reported either as cash and cash equivalents or other invested assets, respectively. (See Section VI.A.8.)

5. UAHC and TennCare agreed the payments under Amendment Number 3 would be limited to the amount necessary to reinstate UAHC's net worth to the statutory net worth requirement as of June 30, 2002. UAHC's reported net worth on the NAIC June 30, 2002 financial statement was $385,729 in excess of the statutory net worth requirement and, thus, should be returned to TennCare. Additionally, UAHC should submit a final actuarial certification for the period July 1, 2001, through June 30, 2002 for amounts reimbursed through Amendment 3. After the actuarially certified excess funding is determined, additional amounts payable to TennCare may be required. (See Section VI.B.)

6. UAHC reported $47,540 in income tax expense on the 2004 NAIC Annual financial statements. The reported income tax expense is based upon UAHC's allocated portion of income tax expense as part of United American Detroit's consolidated tax return. However, UAHC did not seek the required prior approval by TDCI for transactions within a holding company. Additionally, NAIC Statement of Statutory Accounting Principles No. 10 requires where the plan files a consolidated tax return with one or more affiliates, income tax transactions between the affiliated parties can only be recognized pursuant to a written tax allocation agreement. (See Section VI.F.)

B. Claims Processing Deficiencies

1. For all medical and vision processed claims, UAHC did not process claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for the months of March 2005, April 2005 and June 2005. (See Section VII.A.)

2. During examination test work to verify the accuracy of data files submitted to TDCI, it was discovered that UAHC failed to include the processed claims by the subcontractor for vision claims, Block Vision. After several attempts, UAHC was able to obtain data files from Block Vision in the proper format for prompt pay testing. Data for each month was tested in its entirety for compliance with the prompt pay requirement of Tenn. Code Ann. § 56-32-226(b)(1). Separate

analyses of claims processed revealed Block Vision was unable to meet prompt pay requirements for June, August, September, and October 2005 in accordance with Tenn. Code Ann. § 56-32-226(b)(1). (See Section VII.A.)

3. UAHC failed to comply with the claims payment accuracy requirements of Section 2-9. of the CRA for the second quarter 2004, third quarter 2004, fourth quarter 2004, first quarter 2005, third quarter 2005, and fourth quarter 2005. (See Section VII.B.)

4. The following deficiencies were noted in the preparation of the claims payment accuracy reports and procedures to follow-up on deficiencies noted in the claims payment accuracy testing:

   - UAHC and Vestica corrected only claims identified as errors from the 300 claims selected for testing in each quarter. The errors identified by UAHC were the result of improper establishment of the claims processing system payment logic. Testing should have been expanded immediately to determine if other claims paid applied similar incorrect system payment logic. As a result of this failure to follow-up on incorrect system payment logic, material overpayments have occurred. UAHC must correct all overpayments when discovered. Sections 2.9.g.9., Claims Processing Requirements, and 4-3., Errors, of the Contractor Risk Agreement address specifically UAHC's responsibility to recover overpayments and errors. Testing of claims overpayments by TDCI was expanded. As noted below, UAHC agreed to an expanded medical claim overpayment review by a separate vendor operating under the oversight of TDCI to encompass all claims paid since UAHC went into stabilization in May 2002.

   - Block Vision claims were not included in the population from which the claims were sampled until the third quarter 2005 report. All claims processed should be included in the population from which claims are to be selected for testing.

   - The method for selecting claims each month did not include all claim types based on claims forms. Claim types in the processing system are either on HCFA1500 or UB92 claims forms. In January 2005, UAHC only tested claims submitted on HCFA 1500 claims forms. In February 2005, UAHC only tested claims submitted on UB92 claims forms. UAHC should test both types of claims forms for each month tested.

   - The work papers for the third quarter 2005 claims payment accuracy report do not leave a sufficient audit trail because the "Results for each attribute tested for each claim selected" was not maintained for inspection.

   (See Section VII.B.2.)

5. Based upon the medical claims overpayment review for the period May 1, 2002 through June 30, 2005, claims overpayments by UAHC of $5,515,225 were identified. The review identified additional issues beyond the errors noted by UAHC's internal audit. The following is a summary of the issues in which UAHC concurred with the claims consultant's findings. The complete discussion of findings and UAHC comments can be found in the medical claims overpayment review issued December 31, 2005 as an Appendix to this report:

   - Claims were overpaid where service lines included modifier 26.

   - Service lines were overpaid based on provider contracted rates.

   - Ambulance claims were overpaid because items such as medical supplies are being paid that should be included in a flat transportation rate per the contract, and mileage is not being reimbursed at the contracted rate.

   - Claims for a hospital provider were incorrectly paid because the contracted rate for emergency room claims was an all inclusive rate. Services such as MRI and CT scans were incorrectly paid outside of the all inclusive rate.

   - Claims were incorrectly paid at an amount greater than billed charges.

   - Cesarean section case rates were incorrectly applied because the contracted case rate includes the first four days instead of the first three days.

   - Claim service lines which were covered under capitation agreements were incorrectly paid to either the member's capitated group or to another capitated group based upon UAHC's business rules.

   - Monthly PCP assignments data files were interpreted incorrectly resulting in payments for claims which should have paid zero under the terms of capitation agreements.

   - Well baby claims with revenue codes of 170 or 171 covered under the mother's per diem or case rate were incorrectly paid.

   - Per diem payments were incorrectly calculated.

   - Where Medicare was primary on a claim and there was a deductible or coinsurance, coordination of benefits was not correctly considered when determining the payment due.

   - Overpayments for facility claims occurred where the member was eligible for TennCare for a portion of an inpatient stay but not for the entire date span billed.

- Duplicate claims payments were identified for physician claims, inpatient claims, emergency room claims and interim billing payments.

- UAHC incorrectly added a service line with revenue code 191 to process claims when the days billed did not equal the days authorized. This procedure also caused the claims system logic to allow duplicate claims payments resulting in overpayments.

UAHC should continue to improve claims payment accuracy percentages. Monitoring of the claims processing subcontractor should be enhanced. Benefit rules and claims processing system logic should be consistently and correctly applied. UAHC should ensure that all fee tables and disbursement methodologies are accurately configured in Vestica's claims processing system. Current claims payment accuracy percentages indicate the medical claims overpayment review scheduled to begin July 1, 2006 is necessary. (See Section VII.D. and the Appendix)

6. Deficiencies in claim processing by Block Vision were noted. The validity of all procedure codes reported by Block Vision could not be verified by TDCI. Additionally, claims were incorrectly processed because the diagnosis code was for medical services instead of vision services. (See Section VII.E.2.)

D. Compliance Deficiencies

1. For two of the three provider contracts selected for testing, amendments to both contracts were not submitted to TDCI for prior approval as a material modification to UAHC's certificate of authority as required by Tenn. Code Ann. § 56-32-203(c)(1). UAHC should submit any amendments to approved provider contract templates for prior approval by TDCI. (See Section VIII.C.)

2. UAHC operated under the Block Vision subcontract without the prior approval of TDCI. A letter from TDCI on February 23, 2003, advised UAHC that its submission of the material modification of the Block Vision subcontract was deficient. No response was made to correct the deficiencies noted. (See Section VIII.D.1.)

3. Both of the subcontractors for claims processing experienced significant deficiencies. Claims payment accuracy percentages failed to meet CRA requirements of 97%. UAHC internal audits and the medical claims overpayment review noted material overpayments as a result of the claims processing system payment logic. Vision claims were not processed timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1). TDCI recommends that UAHC implement the following procedures to improve the monitoring subcontractors:

   - When the internal auditor notes deficiencies by the subcontractor, testing should be expanded to determine if other claims paid have applied similar incorrect system payment logic.

- The testing for claims payment accuracy by UAHC's internal auditor did not identify all of the deficiencies noted by the claims consultant. To ensure that the internal auditor does identify deficiencies in the future, the internal audit department should supplement claims payment accuracy testing with similar computerized audit techniques utilized by the claims consultant. These techniques can be designed to search for payment errors such as duplicate payments made by the subcontractor. Several auditing software packages are available by outside vendors. A key to applying computerized audit techniques is to have an accurate data warehouse. TDCI found that UAHC's data warehouse of previously processed claims was incomplete since it did not include adjusted claims.

- UAHC should clearly document the business rules for the subcontractor to utilize in processing claims. During the medical claims overpayment review, it was discovered the subcontractor was applying old business rules previously supplied by UAHC.

- UAHC should complete an audit of all fee tables loaded in the claims processing system. During the medical claims overpayment review, errors continued to be found in the fee tables established in the claims processing system as compared to contracted provider rates. In many instances, the subcontractor relied upon emails sent from UAHC officials to determine the appropriate payment rates.

- UAHC should gain a clearer understanding of the claim processing system utilized by the subcontractor. At the beginning of fieldwork, UAHC's only access to the subcontractor's claims processing system was through a limited web inquiry. The web inquiry was insufficient since it did not allow UAHC to review relevant modules of the subcontractor's claims processing system including member eligibility, provider maintenance, authorization system, fee tables and other processing modules. During the medical claims overpayment review, the claims consultant and UAHC gained the necessary access to the subcontractor's claims processing system through inquiry-only mode.

(See Section VIII.D.2.)

4. The following deficiencies were noted in UAHC's internal audit department:

   - Although the internal auditor noted significant deficiencies in claims payment by the claims processing subcontractor, UAHC did not expand testing to determine if other claims paid have applied similar incorrect system payment logic. As a result of this failure to follow-up on incorrect system payment logic, material overpayments occurred. UAHC should establish procedures to carefully consider noted errors by the internal auditor and appropriately research if others claims were incorrectly processed in the same manner.

- The procedures to prepare claims payment accuracy reports were deficiencient because of inadequate sample selection methods and the failure to maintain sufficient audit trail of attributes tested.

- The internal auditor should also perform focused reviews to determine UAHC's compliance with CRA requirements including the conflict of interest requirements.

(See Section VIII.H.)

5. In 2005, several media reports linked former State Senator John Ford to UAHC and possible violations of conflict of interest requirements of the CRA. Sections 4-7. of the CRA warrants that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to UAHC in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration. On April 15, 2005, United American Detroit stated it contracted with former State Senator John Ford for consulting services to "explore expansion of its business to other southern states beyond Tennessee…" The State Attorney General's Office, Tennessee Registry of Election Finance, and the Tennessee Bureau of Investigation have initiated investigations into the transactions between United American Detroit and former State Senator John Ford.

   UAHC agreed to deposit into escrow with TennCare $420,500 for the amounts paid to former State Senator John Ford. In depositing such amount into escrow, UAHC specifically denied that it has in any way breached the CRA and affirms that it is making the payment in good faith for the security of TennCare.

   As of the release of this examination report, investigations of payments by United American Detroit to former State Senator John Ford and possible violations of conflict of interest requirements of the CRA have not been concluded. The escrow deposit for $420,500 remains in effect.

   TDCI recommends that UAHC, United American Tennessee and United American Detroit implement the following procedures to enhance compliance with the CRA including conflict of interest requirements:

   - Since the only HMO controlled by United American Detroit is UAHC, the TennCare plan, members of the board of directors and officers of United American Detroit should be held to the same annual reaffirmation of the code of conduct disclosures required by employees of the management company. The directors and officers of United American Detroit have the

same responsibility as United American Tennessee employees to ensure compliance with all of the terms of the CRA.

- This examination report included multiple deficiencies in TennCare operations including overpayment of Federal and State dollars and failures in the monitoring of subcontractors. The board of directors and the officers of UAHC and United American Detroit's oversight of UAHC should focus on the correction of deficiencies in TennCare operations.

- Internal audit department should perform focused reviews to determine UAHC's compliance with CRA requirements including the conflict of interest requirements. Through internal audit, the board of directors should ensure that management adheres to internal controls established.

(See Section VIII.I.)

VI. DETAIL OF TESTS CONDUCTED – FINANCIAL ANALYSIS

A. Financial Analysis

As an HMO licensed in the State of Tennessee, UAHC is required to file annual and quarterly NAIC financial statements in accordance with NAIC and statutory guidelines with the Tennessee Department of Commerce and Insurance. The department uses the information filed on these reports to determine if UAHC meets the minimum requirement for statutory reserves. The statements are filed on a statutory basis of accounting. Statutory accounting differs from generally accepted accounting principles because "admitted" assets must be easily convertible to cash, if necessary, to pay outstanding claims. "Non-admitted" assets such as furniture, equipment, and prepaid expenses are not included in the determination of plan assets and should not be considered when calculating capital and surplus.

At December 31, 2004, UAHC reported $12,850,424 in admitted assets, $1,178,466 in liabilities and $11,671,958 in capital and surplus on its annual NAIC statement. UAHC reported total net income of $2,598,968 on its statement of revenue and expenses.

1. Capital and Surplus

Tenn. Code Ann. § 56-32-212(a)(2) requires UAHC to establish and maintain a minimum net worth equal to the greater of (1) $1,500,000 or (2) an amount totaling 4% of the first $150 million of annual premium revenue earned for the prior calendar year, plus 1.5% of the amount earned in excess of $150 million for the prior calendar year.

Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health

care services pursuant to any federal waiver received by the state that waives any or all of the provisions of the federal Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan..." Based on this definition, all TennCare payments made to an HMO licensed in Tennessee are to be included in the calculation of net worth and deposit requirements, regardless of the reporting requirements for the NAIC statements.

Statutory Net Worth Calculation

UAHC's premium revenues per documentation obtained from the TennCare Bureau totaled $237,663,289 for the calendar year 2004; therefore, based upon Tenn. Code Ann. § 56-32-212(a)(2), UAHC's statutory net worth requirement is $7,314,949. UAHC reported total capital and surplus of $11,671,958 as of December 31, 2004 is $4,357,009 in excess of the minimum statutory net worth requirement.

Premium Revenue for the Examination Period

The following is a summary of UAHC's premiums for the examination period January 1, 2004 through December 31, 2004, as defined by Tenn. Code Ann. § 56-32-212(a)(2):

Administrative fee payments from the TennCare Bureau for the period January 1 through December 31, 2004	$20,605,834
Reimbursement for covered services from the TennCare Bureau for the period January 1 through December 31, 2004	212,421,811
Reimbursement for premium tax payments from the TennCare Bureau for the period January 1 through December 31, 2004	4,635,644
Total premium revenue January 1 through December 31, 2004	$237,663,289

2. Restricted Deposit

Tenn. Code Ann. § 56-32-212(b)(2) and (3) requires all HMOs licensed in the state to maintain a deposit equal to $900,000, plus an additional $100,000 for each $10 million or fraction thereof of annual premium revenue in excess of $20 million and less than $100 million as reported on the most recent annual financial statement filed with TDCI, plus $50,000 for each $10 million or fraction thereof of annual premium revenue in excess of $100 million. As previously noted, Tenn. Code Ann. § 56-32-212(a)(2) includes in the definition of premium revenue "any and all payments made by the state to any entity providing health

care services pursuant to any federal waiver received by the state that waives any or all of the provisions of the federal Social Security Act (title XIX), and regulations promulgated pursuant thereto, or pursuant to any other federal law as adopted by amendment to the required title XIX state plan..."

Based upon premium revenues for calendar year 2004 totaling $237,663,289, UAHC's statutory deposit requirement at December 31, 2004, was $2,400,000. UAHC has on file with TDCI the necessary safekeeping receipts documenting that deposits totaling $2,400,000 have been pledged for the protection of the enrollees in the State of Tennessee. Subsequently, an amendment to CRA as of July 1, 2005, changed the deposit requirements to equal the calculated statutory net worth. UAHC increased the deposits pledged for the protection of the enrollees in the State of Tennessee to $7,315,000 to comply with the CRA.

3. Management Agreement

UAHC contracts with United American Tennessee to provide management services. The management fee paid to United American Tennessee was 90% of the administrative fees earned by UAHC under the TennCare program. The management agreement defines that all expenses including office space shall be paid by United American Tennessee with the exception of direct medical expenses, board of director costs, accounting, actuarial, legal, premium taxes and other fees approved by the board of the directors. On December 20, 2004, the terms of the management agreement were not followed because United American Tennessee entered into a lease agreement with UAHC as the lessee. Operation by UAHC under the lease agreement was in a manner contrary to information submitted to TDCI to obtain and maintain its certificate of authority to operate as a HMO. The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operation documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). On June 23, 2005, UAHC submitted for approval to TDCI as a material modification to its certificate of authority an amended and restated management agreement where management fees are reduced by the office building lease payments. On July 12, 2005, TDCI approved amended and restated management agreement.

Management's Comments

Management agrees with this finding.

4. Allocation of Management Fees

For NAIC financial statement reporting purposes, management fees must be apportioned to the administrative expense categories defined on NAIC annual and quarterly financial statements. The NAIC's Statement of Statutory Accounting Principles No. 70 requires that expenses under a management contract shall be apportioned to the entities incurring the expense as if the expense has been paid solely by the incurring entity.

During the examination, United American Tennessee incurred expenses for management services related to UAHC and start-up expenses for out of state operations.

Before allocation of the management fee to expense categories on the NAIC Underwriting and Investment Exhibit – Part 3, UAHC did not specifically identify direct costs related to services for start-up expenses for out of state operations. Direct costs incurred by the start-up operations include salaries and consulting fees.

UAHC should improve the methodology utilized for the allocation of management fees to NAIC expense categories by initially identifying salaries and compensation incurred by United American Tennessee which are 100% related to UAHC or other operations. Direct costs that are related 100% to specific operations should be allocated to the specific operations before other pertinent ratios are applied. Any change to the methodology will not affect reported net income or net worth but the improved methodology will provide a more accurate representation of administrative expenses on NAIC financial statements.

Management's Comment

Management agrees with the finding and has improved the methodology for allocation of management fees to NAIC expense categories. UAHC has satisfied the requirements by preparing and maintaining detailed supporting schedules to verify the allocation of claims adjustment expenses.

5. Claims Payable

As of December 31, 2004, UAHC reported no claims payable on the NAIC annual statement. This amount represented an estimate of unpaid claims or incurred but not reported (IBNR) for only the "at risk" period ending June 30, 2002. Review of claims processing system payments after December 31, 2004, determined that the reported claims payable appears reasonable.

6. Interest Earned on State Funds

Section 3-10.h.2(d) of the CRA states interest generated by funds on deposit for provider payments related to the no risk agreement period shall be the property of the State. Based on TDCI's review, UAHC is in compliance with this requirement

7. Recovery Amounts/Third Party Liability

Section 3-10.h.2.(f) of the CRA requires third party liability recoveries and subrogation amounts related to the no risk agreement period be reduced from medical reimbursement requests of the TennCare Bureau.

Amendment Number 3 to CRA provided additional funds of $7,500,000 to UAHC for the costs of medical services for dates of service July 1, 2001 through June 30, 2002. On October 4, 2002, the State of Tennessee Department of Finance and Administration TennCare and UAHC entered into a Memorandum of Understanding which stated the intent of the State to amend the UAHC CRA should certified actuarial data confirm that additional funds are needed beyond $7,500,000 provided in Amendment Number 3. Essentially, Amendment 3 and the Memorandum of Understanding provided no risk funding to pay additional funds to UAHC for cost of future certified actuarial data for medical claims incurred prior to June 30, 2002. Third party recoveries, subrogation, and claims payment recoveries related to funding received through Amendment 3 were not returned to the State of Tennessee.

UAHC recovered third party liability and subrogation of $79,914 through August 17, 2005 that were previously reimbursed by the State through Amendment 3 funding. As of the examination fieldwork date, UAHC had not remitted any of these amounts to the State. As third party liability and subrogation amounts are recovered from no risk funding, UAHC should reduce the next medical reimbursement request to the TennCare Bureau for the amounts recovered. An examination adjustment to net worth for $79,914 is required. (See Section VI.G.)

Management's Comment

Subrogation recoveries of $79,914 were remitted to the State on January 17, 2006.

8. Cash and Cash Equivalents Classification Error

On the 2004 NAIC Annual financial statement certificate of deposits of $3,605,000 were incorrectly reported as bonds. Certificates of deposits depending on a maturity date either less than one year or greater than one year should be reported either as cash and cash equivalents or other invested assets, respectively. The reclassification of certificates of deposits from bonds to either cash and cash equivalents or other invested assets will not require an adjustment to reported net income or net worth.

Management's Comment

The classification of certificate of deposits as bonds was an inadvertent classification error that will not require an adjustment to reported net income or net worth.

B. Amendment Number 3 Funding

Through Amendment Number 3 UAHC selected Risk Option 2 for the period July 1, 2001 through April 30, 2002, and UAHC was reimbursed on a no risk basis for medical services for the period May 1, 2002 through June 30, 2002. Additionally

UAHC and TennCare agreed the payments under Amendment Number 3 would be limited to the amount necessary to reinstate UAHC's net worth to the statutory net worth requirement as of June 30, 2002.

On October 4, 2002, the State of Tennessee Department of Finance and Administration TennCare and UAHC entered into a Memorandum of Understanding which stated, "It is the intent of the State to amend the OmniCare [UAHC] Contractor Risk Agreement should certified actuarial data confirm that additional funds are needed beyond the $7,500,000 provided in Amendment Number 3 to the Contractor Risk Agreement. OmniCare [UAHC] will provide all actuarial or other data requested by the State for review and analysis. The data to be reviewed is for the period July 1, 2001 through June 30, 2002."

A comparison of the reported capital and surplus versus the required statutory net worth as of June 30, 2002 indicates UAHC exceeded the statutory net worth requirements. This calculation must be updated and adjusted by UAHC to recognize financial adjustments for dates of service prior to July 1, 2002 that have occurred since the submission of the NAIC June 30, 2002 financial statement.

Reported Capital and Surplus as of June 30, 2002 Submitted December 9, 2002	$4,929,978
Statutory Net Worth Required as of June 30, 2002	4,544,249
Excess Net Worth	$385,729

A sufficient run out of claims for dates of service July 1, 2001 through June 30, 2002 has occurred to determine the amount of funds needed to achieve the minimum statutory net worth requirement as of June 30, 2002. UAHC should submit a final actuarial certification for the period July 1, 2001 through June 30, 2002 for amounts reimbursed through Amendment 3. The calculation should include recognition of amounts collected from claims recoveries after June 30, 2002 which increased net worth as June 30, 2002. Also the calculation should indicate if Amendment Number 3 and the Memorandum of Understanding funding reinstated UAHC's net worth beyond the statutory net worth requirement as of June 30, 2002. The updated and adjusted excess funding should be returned to the State. An examination adjustment to net worth for $385,729 is required (See Section VI.G.). Additional adjustments to net worth may be payable to the TennCare Bureau if additional excess funding is determined by an actuary.

Management's Comment

Management does not agree with the assertion that an adjustment of $385,729 is required to the June 30, 2002 statutory filing nor does management believe there is excess Amendment 3 funding that should be returned to the State. Any excess funding was applied, with TennCare approval, to the settlement of litigation with Vanderbilt.

A lawsuit filed by Vanderbilt alleged that Omnicare (now UAHC) breached a contract by paying less than the plaintiff's full charges for health services for the recovery of claims for medical services provided to UAHC enrollees for the period from May 1, 2002 through August 31, 2003. On April 15, 2004 UAHC received written approval from TennCare Deputy Commissioner, Manny Martins, for release of funds previously paid to UAHC by TennCare in the amount of $856,258.44 for the settlement with Vanderbilt.

UAHC will provide copies of the corresponding documents from the TennCare Bureau for this transaction.

TDCI Rebuttal:

TDCI's interpretation of Amendment 3 and the related Memorandum of Understanding indicates a final actuarial certification should be performed. The certification should determine if excess funding should be returned to the state. The TennCare Bureau would ultimately determine the necessity of the actuarial certification and the possible return of any excess funding.

C. Administrative Services Only (ASO)

As previously mentioned, the CRA between UAHC and the State of Tennessee does not hold UAHC financially responsible for medical claims incurred through December 31, 2006. This type of arrangement is considered "administrative services only" (ASO) as defined by the NAIC guidelines. Under the NAIC guidelines for ASO lines of business, the financial statements for an ASO exclude all income and expenses related to claims, losses, premiums, and other amounts received or paid on behalf of the uninsured ASO. In addition, administrative fees and revenue are deducted from general administrative expenses. Further, ASO lines of business have no liability for future claim payments, thus, no provisions for IBNR are reflected in the balance sheet. Although UAHC is under an ASO arrangement as defined by NAIC guidelines, the CRA requires a deviation from those guidelines. The required submission of the TennCare Operating Statement should include quarterly and year-to-date revenues earned and expenses incurred as a result of the contractor's participation in the State of Tennessee's TennCare program as if UAHC were still operating at-risk. As stated in section 2-10.i. of the CRA, UAHC is to provide "an income statement addressing the TennCare operations." TennCare HMOs provide this information on the Report 2A. No deficiencies were noted in preparation of the Report 2A for the period ending December 31, 2004.

D. Medical Fund Target

Effective July 1, 2002, the CRA requires UAHC to submit a Medical Fund Target (MFT) on a monthly basis. The MFT accounts for medical payments and IBNR based upon month of service as compared to a target monthly amount for the enrollees' medical expenses. Although estimates for incurred but not reported claims for ASO plans are not included in the NAIC financial statements, these

estimates are required to be included in the MFT. UAHC submitted monthly MFT reports which reported actual and estimated monthly medical claims expenditures to be reimbursed by the TennCare Bureau. The estimated monthly expenditures are supported by a letter from an actuary which indicates that the MFT estimates for IBNR expenses have been reviewed for accuracy. No discrepancies were noted during the review of documentation supporting the amounts reported on the Medical Fund Target report.

E. Escrow Payments Per Memorandum of Understanding June 22, 2005

Subsequent to the examination period, UAHC agreed with the TennCare Bureau to the following Escrow Agreement:

1. Examination testing by TDCI determined that potential material claims overpayments had been made. These potential material overpayments and the resulting claims overpayment review are discussed in Section VII.D. of this report. As a result, UAHC agreed to deposit into escrow $2,300,000, the amount represents approximately 1% of all UAHC medical payments in fiscal year 2005. UAHC also agreed to an immediate and comprehensive, multi-year audit of all processed claims to be completed by a vendor selected by and operating under the oversight of TDCI. UAHC reimbursed the state for all cost associated with this process.

   The escrow deposit account shall terminate two years from the date on which the deposit was made or six months after the conclusion of the investigations now being conducted by both state and federal authorities, whichever first occurs unless the parties agree otherwise before that date. The resulting claims overpayment review determined overpayments of $5,515,224.77 for the period May 1, 2002 through June 30, 2005. In responses to the claims overpayment review, UAHC has asserted that most of the overpayments were recouped from medical providers. The $2,300,000 on deposit will remain in escrow until the claims overpayment review for dates of service July 1, 2005 through June 30, 2006, is completed after June 30, 2006. In determining the maximum potential examination adjustments to net worth, TDCI has adjusted net worth by $2,300,000 as a potential liability for overpayments (See Section VI.G.). This amount may be adjusted again once UAHC has demonstrated to TennCare and TDCI that all overpayments were collected or returned to the State.

2. In response to TennCare Bureau inquiries regarding potential breaches of conflict of interest requirements of the CRA, UAHC indicated former State Senator John Ford was paid $420,500 since April 2001 in consulting fees by United American Detroit (See Section VIII.I). UAHC agreed to deposit into escrow $420,500. Although UAHC specifically denied that it had breached the CRA, it established the escrow in good faith for the security of TennCare. TennCare did not assert that at the time of the escrow payment UAHC had breached the CRA, but it had requested that certain monies be deposited in an interest-bearing account to preserve its rights in the event of the termination of

the CRA by its terms. An examination adjustment is not required since the funds made available for deposit were provided by the management company, United American Tennessee, and not UAHC.

F. Allocation of Income Tax Expense

UAHC reported $47,540 in income tax expense on the 2004 NAIC Annual financial statements. The reported income tax expense is based upon UAHC's allocated portion of income tax expense as part of United American Detroit's consolidated tax return. Tenn. Code Ann. § 56-32-206(a)(2) requires the HMO to notify and seek approval by the Commissioner in writing of its intention to enter into certain transactions within a holding company at least thirty days prior to the transaction. Specifically § 56-11-206(a)(2)(D) states, "All management agreements, service contracts and all cost-sharing arrangements other than cost allocations arrangements based on generally accepted accounting principles…" Additionally, NAIC Statement of Statutory Accounting Principles No. 10 requires, where the plan files a consolidated income tax return with one or more affiliates, income tax transactions between the affiliated parties can only be recognized pursuant to a written tax allocation agreement.

UAHC should ensure that agreements per § 56-11-206(a)(2)(D) within the holding company are prior approved by TDCI. Subsequent to the examination period on November 23, 2005, UAHC submitted a tax sharing agreement to TDCI for approval as a material modification to its certificate of authority pursuant to § 56-32-203(c). TDCI approved the tax sharing agreement on December 13, 2005.

Management's Comments

Management agrees with this finding.

G. Schedule of Examination Adjustments to Capital and Surplus

The effect of examination adjustments is as follows:

Reported Capital and Surplus as of December 31, 2004	$11,671,958
Less: Claims Recoveries Reimbursed through Amendment 3 (See Section VI.A.7.)	79,914
Less: Excess Funding From Amendment Number 3 and the Memorandum of Understanding (See Section VI.B.)	385,729
Adjusted Capital and Surplus as of December 31, 2004	11,206,315
Required Statutory Net Worth December 31, 2004	7,314,949
Excess Statutory Net Worth	$3,891,366

The examination adjustments did not reduce capital and surplus below required statutory net worth requirements.

Potential liabilities exist if UAHC is unable to collect all claims overpayments. UAHC has indicated it has collected the majority of claims overpayments. This will be confirmed on the next claims overpayment review scheduled after June 30, 2006. In determining if claims overpayments will affect UAHC required statutory net worth, the amount of the escrow payment was considered as the maximum potential liability.

Adjusted Capital and Surplus as of December 31, 2004	$11,206,315
Less: Escrow Payment Established For Medical Claims Overpayment Audit (See Section VI.E.)	2,300,000
Capital and Surplus as of December 31, 2004 Adjusted for Potential Claims Overpayment Liability	8,906,315
Required Statutory Net Worth December 31, 2004	7,314,949
Potential Excess Statutory Net Worth	$1,591,366

Even after considering potential examination adjustments for uncollected overpayments, UAHC would maintain capital and surplus in excess of statutory net worth requirements as of December 31, 2004. The final effect on the capital and surplus can be determined once UAHC has demonstrated to TennCare and TDCI that all overpayments were collected or returned to the State and if any adjustment is necessary based on the actuarial certification required to reconcile Amendment Number 3 funding.

Management's Comments

Management does not concur with the Adjusted Capital and Surplus calculation above as of December 31, 2004, as it includes a disputed finding related to Amendment 3 funding ($385,729). In addition, management believes that all undisputed identified overpayments identified during the claims audit will be recouped from providers with little or no impact to the Company's statutory net worth position. Management thus believes the Potential Excess Statutory Net Worth amount calculated above to be understated.

TDCI Rebuttal:

As previously mentioned, TDCI's interpretation of Amendment 3 and the related Memorandum of Understanding indicates a final actuarial certification should be performed. The certification should determine if excess funding should be returned to the state. The TennCare Bureau would ultimately determine the

necessity of the actuarial certification and the possible return of any excess funding.

VII. DETAIL OF TESTS CONDUCTED – CLAIMS PROCESSING SYSTEM

A. Time Study of Claims Processing

The purpose of conducting a time study of claims is to determine whether claims were adjudicated within the time frames set forth in Tenn. Code Ann. § 56-32-226(b)(1) and Section 2-18. of the CRA. The statute mandates the following prompt payment requirements:

> The health maintenance organization shall ensure that ninety percent (90%) of claims for payments for services delivered to a TennCare enrollee (for which no further written information or substantiation is required in order to make payment) are paid within thirty (30) calendar days of the receipt of such claims. The health maintenance organization shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all provider claims for services delivered to an enrollee in the TennCare program.
>
> > (A) "Pay" means that the health maintenance organization shall either send the provider cash or cash equivalent in full satisfaction of the allowed portion of the claim, or give the provider a credit against any outstanding balance owed by that provider to the health maintenance organization.
> >
> > (B) "Process" means the health maintenance organization must send the provider a written or electronic remittance advice or other appropriate written or electronic notice evidencing either that the claim had been paid or informing the provider that a claim has been either partially or totally "denied" and specify all known reasons for denial. If a claim is partially or totally denied on the basis that the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice must specifically identify all such information and documentation.

TDCI previously requested the following months data files from UAHC during the examination period and months subsequent to the examination period. Data for each month was tested in its entirety for compliance with the prompt pay requirement of Tenn. Code Ann. § 56-32-226(b)(1).

	Clean Claims Within 30 days	All Claims Within 60 days	Compliance
T.C.A. Requirement	**90%**	**99.5%**	
January 2004	94%	99.8%	**Yes**
April 2004	100%	100.0%	**Yes**
July 2004	100%	100.0%	**Yes**
October 2004	100%	100.0%	**Yes**
January 2005	100%	100.0%	**Yes**
February 2005	100%	100.0%	**Yes**
March 2005	80%	100.0%	**No**
April 2005	68%	100.0%	**No**
May 2005	90%	100.0%	**Yes**
June 2005	73%	100.0%	**No**
July 2005	99%	99.9%	**Yes**
August 2005	99%	99.9%	**Yes**
September 2005	99%	100%	**Yes**
October 2005	99%	100%	**Yes**

For all medical and vision processed claims, UAHC did not process claims timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1) for the months of March 2005, April 2005 and June 2005.

Management's Comment

Management agrees with this finding. The non-compliance during the three-month period was due to a process change for claims payment to accommodate the funding schedule by the TennCare Bureau, which has since been corrected. UAHC has paid all medical claims in accordance with TCA, since July 2005.

During examination test work to verify the accuracy of data files submitted to TDCI, it was discovered that UAHC failed to include the processed claims by the subcontractor for vision claims, Block Vision. After several attempts, UAHC was able to obtain data files from Block Vision in the proper format for prompt pay testing. Data for each month was tested in its entirety for compliance with the prompt pay requirement of Tenn. Code Ann. § 56-32-226(b)(1).

	Clean Claims Within 30 days	All Claims Within 60 days	Compliance
T.C.A. Requirement	90%	99.5%	
June 2005	64%	100%	**No**
August 2005	80%	96.8%	**No**
September 2005	64%	99.1%	**No**
October 2005	67%	98.2%	**No**

Separate analysis of claims processed revealed Block Vision was unable to meet prompt pay requirements of Tenn. Code Ann. § 56-32-226(b)(1) for June, August, September, and October 2005. UAHC notified TDCI on August 16, 2005, that Block Vision's Administrative Service Agreement had been cancelled. Vestica began processing vision claims with dates of service after the Block Vision termination. TDCI has requested UAHC to continue to submit Block Vision data files until processing of all claims in inventory at Block Vision is complete.

Management's Comment

Management agrees with this finding; however must formally note that the TDCI Examiner purposely chose to single out the Block visions claims and have them audited separately and not in total aggregate with all other medical claims. Block Vision claims volume represented less than 1% ($404,267.68) of total claims paid during above referenced period. In aggregate (i.e. inclusion of medical and vision claims), UAHC was compliant with TCA prompt pay provisions for claims processing. Effective December 1, 2005, UAHC transitioned vision claims processing to Vestica.

B. Claims Payment Accuracy Reports

Section 2-9. of the CRA requires that 97% of claims are paid accurately upon initial submission. UAHC is required to submit a quarterly claims payment accuracy report 30 days following the end of each quarter.

UAHC self reported to TennCare and TDCI the following results for 2004 and 2005:

CRA Requirement	97%	Compliance
1st Quarter 2004	100%	**Yes**
2nd Quarter 2004	96%	**No**
3rd Quarter 2004	93%	**No**
4th Quarter 2004	92%	**No**
1st Quarter 2005	92%	**No**
2nd Quarter 2005	97%	**Yes**
3rd Quarter 2005	92%	**No**
4th Quarter 2005	96%	**No**

UAHC failed to comply with the claims payment accuracy requirements of Section 2-9. of the CRA for the second quarter 2004, third quarter 2004, fourth quarter 2004, first quarter 2005, third quarter 2005, and fourth quarter 2005.

Management's Comments

Management agrees with this finding.

TDCI became concerned about the continued decrease in the claims payment accuracy percentages reported. After the submission of the fourth quarter 2004 report on January 30, 2004, TDCI requested UAHC to provide a corrective action plan to include the following:

1. Explain the reason for the noncompliance with the required claims payment accuracy percentages. Provide the detailed sample results for the fourth quarter 2004 including the reasons the claims were improperly processed.

2. Provide the audit procedures and sample methodology UAHC used to prepare the claims accuracy report.

3. Provide the corrective actions that UAHC will develop to achieve compliance with the claims payment accuracy percentage in the future.

On March 28, 2005, TDCI received UAHC's corrective action plan related to the fourth quarter 2004 claims payment accuracy report. TDCI reviewed the corrective action plan. Claims payment accuracy testing by UAHC revealed that most of the errors reflected improper establishment of the claims processing system payment logic. This included the inaccurate application of UAHC's business rules for specific procedure codes resulting in payments not in agreement with rates established in

provider contracts. On April 14, 2005, TDCI requested UAHC to provide additional explanations including the following:

1. The reason or factors that the errors found in the claims payment accuracy testing occurred;

2. Whether other claims paid to the same provider or by the same procedure codes resulted in incorrect payments and when these errors will be reprocessed; and

3. Actions to ensure that all fee tables and disbursement methodologies are accurately configured in Vestica's claims processing system.

On May 2, 2005, UAHC responded that UAHC would perform an in-depth claims audit to see if other claims paid to the same provider or by the same procedure codes resulted in incorrect payments, and if so UAHC (Vestica) would reprocess and correct any such errors. UAHC reported that this in-depth claims audit would be completed May 13th 2005. Further, UAHC indicated it had implemented the following actions to ensure all fee tables and disbursements methodologies are accurately configured in Vestica's claims processing system:

1. UAHC indicated it has improved its monitoring efforts of Vestica by performing a quarterly audit for the accuracy of all fee tables loaded in the claims processing system.

2. Vestica is required to send UAHC an excel spreadsheet of all providers and their fee schedules. The data is audited to the contract and the in-house provider services fee tables to ensure that all of the tables loaded by Vestica are an exact match to the corresponding provider's contracts.

3. Upon execution of provider agreements, Vestica is forwarded a hard copy of the fee schedule and an electronic fee schedule to be loaded. Upon receipt and loading, Vestica is required to submit an electronic copy of the loaded fee table for verification by the accuracy of the load. This function is performed by the Contract Administrative Specialist.

The examination field work began on April 25, 2005. TDCI considered the corrective action plan and follow-up response in review of the results of the claims payment accuracy reports. See below the results of TDCI's review of claims payment accuracy reporting.

1. Procedures to Review the Claims Payment Accuracy Reporting

   The review of the claims processing accuracy report included an interview with responsible staff to determine the policies, procedures, and sampling methodologies surrounding the preparation of the claims payment accuracy report. These interviews were followed by a review of the supporting documentation used to prepare the fourth quarter 2004 and first quarter 2005

claims payment accuracy reports. This review included verification that the number of claims reviewed constituted an adequate sample to represent the population.

In addition, claims were selected at random by TDCI from the MCO's fourth quarter 2004 and first quarter 2005 claims payment accuracy reports. These claims were reviewed to determine if the information on the supporting documentation was correct. The supporting documents were tested for mathematical accuracy. The amounts from the supporting documentation traced directly to the actual report filed with TennCare. Also, all claims identified in the report with errors were reviewed to ensure the errors have been corrected and the errors were manual and not the result of the failure of claims processing system rules.

Further, TDCI reviewed UAHC's third quarter 2005 Claims Payment Accuracy report to determine if UAHC had incorporated the claims processing changes in the CRA effective July 1, 2005.

As previously noted, UAHC failed to meet claims payment accuracy percentages required by the CRA. UAHC responded to a TDCI request for a corrective action plan and follow-up explanations. TDCI was particularly concerned that other claims paid to the same provider or by the same procedure codes resulted in incorrect payments and whether UAHC had ensured that all fee tables and disbursement methodologies were accurately configured in Vestica's claims processing system. Results of the claims payment accuracy revealed the following deficiencies:

- Incorrect application and payment of percentage discounts on procedure codes with modifiers
- Incorrect application and payment of percentage of Medicare 2001 rates as stated in provider contracts
- Hospital outpatient paid at an incorrect percentage of billed charges
- Payment of units instead of per diem
- Per diem payments paid twice (duplicate) on the same date of service for the same claim
- Contracted providers incorrectly paid the non-par rate versus the negotiated rate
- Claims incorrectly paid fee-for-service when the claims should have paid $0 as a capitated service

UAHC has the responsibility to identify and collect and return all overpayments to the TennCare Bureau for claims with date of service beginning May 1, 2002. The CRA with UAHC was amended for this period to operate under a no risk agreement. Payment for medical providers is funded directly by the TennCare Bureau during this period, otherwise known as the "stabilization period". UAHC is ultimately responsible for the return of any overpayments that are made during stabilization.

Section 2-9.g.9. of the CRA states:

> The CONTRACTOR shall use its best efforts to recover overpayment of benefits that result from errors of the CONTRACTOR. Should the CONTRACTOR inadvertently make payment, arising from errors in overpayment, the amount of overpayment actually recovered should be credited to the State within forty-five (45) calendar days after recovery of the overpaid funds by the CONTRACTOR. In the event any overpayment is not recovered within 90 calendar days of discovery of the overpayment - and if the State has already made payment of the claims that included the overpayment - the CONTRACTOR will credit the State for the amount of the overpayment by the ninetieth (90) day.

Section 4-3. of the CRA states:

> The CONTRACTOR is expected to prepare carefully all reports for submission to TENNCARE. If after preparation and submission, a CONTRACTOR error is discovered either by the CONTRACTOR or TENNCARE, the CONTRACTOR has fifteen (15) calendar days, where practical, after written notification to correct the error and submit accurate reports and/or invoices. Similarly, errors on TENNCARE's part identified by the CONTRACTOR shall be corrected within fifteen (15) calendar days, where practical, of receipt of written notification by the CONTRACTOR.

Section 4-8.c. of the CRA states:

> If it is determined that there is a claims processing deficiency related to the MCO's ability/inability to reimburse providers in a reasonably timely and accurate fashion as required by Section 2-9.g, TENNCARE shall provide a notice of deficiency and request corrective action. The CONTRACTOR may also be subject to the application of intermediate sanctions specified in Section 4-8 and the retention of withholds as specified in Section 3-10. If the CONTRACTOR is unable to successfully implement corrective action and demonstrate adherence with timely claims processing requirements within the time approved by TENNCARE, the CONTRACTOR agrees the State may terminate this Agreement in accordance with Section 4-2.b of this Agreement.

2. Results of Review of the Claims Payment Accuracy Reporting

   The following deficiencies were noted in the preparation of claims payment accuracy reports and procedures to follow-up on deficiencies noted in the claims payment accuracy testing:

   - UAHC and Vestica corrected only claims identified as errors from the 300

claims selected for testing in each quarter. The errors identified by UAHC were the result of improper establishment of the claims processing system payment logic. Testing should have been expanded immediately to determine if other claims paid applied similar incorrect system payment logic. As a result of this failure to follow-up on incorrect system payment logic, material overpayments have occurred. UAHC must correct all overpayments when discovered. Sections 2.9.g.9., Claims Processing Requirements, and 4-3., Errors, of the CRA address specifically UAHC's responsibility to recover overpayments and errors. Testing of claims overpayments by TDCI was expanded. As noted below, UAHC agreed to an expanded medical claim overpayment review by a separate vendor operating under the oversight of TDCI to encompass all claims paid since UAHC went into stabilization in May 2002.

- Block Vision claims were not included in the population from which the claims were sampled until the third quarter 2005 report. All claims processed should be included in the population from which claims are to be selected for testing.

- The method for selecting claims each month did not include all claim types based on claims forms. Claim types in the processing system are either on HCFA1500 or UB92 claims forms. In January 2005, UAHC only tested claims submitted on HCFA 1500 claims forms. In February 2005, UAHC only tested claims submitted on UB92 claims forms. UAHC should test both types of claims forms for each month tested.

- The work papers for the third quarter 2005 claims payment accuracy reporting do not leave a sufficient audit trail because the "Results for each attribute tested for each claim selected" was not maintained for inspection.

Management's Comments

Management has taken necessary corrective action to correct the findings above. Effective, May 2005, UAHC selects both HCFA and UB92 forms to audit based on the proportionate total of claims processed for the period. Effective December 2005, vision claims processing was transitioned to Block, thus eliminating the requirement for an audit of the separate population.

In December 2005, UAHC engaged an outside public accounting firm to perform a detailed review of our monthly claims audit process. As a result, the Company has made significant improvements. Our claims documented audit program has been expanded to include procedures for error analysis and resolution. The expanded procedures have been implemented retroactively to July 2005.

C. Determination of the Extent of Test Work of the Claims Processing System

Several factors were considered in the determination of the extent of testing performed on UAHC's claims processing system.

The following items were reviewed to determine the risk that UAHC had not properly processed claims:

- Prior examination findings related to claims processing
- Complaints or Independent Reviews on file with TDCI related to accurate claims processing
- Adequacy of UAHC monitoring procedures for subcontractors
- Results of prompt pay testing by TDCI
- Results reported on the claims payment accuracy reports submitted to TDCI and the TennCare Bureau
- Review of the preparation of the claims processing accuracy reports
- Review of internal controls

As noted in this report, TDCI discovered significant deficiencies in UAHC's monitoring of both claims processing subcontractors, results of prompt pay testing, results of claims payment accuracy reports, procedures to prepare claims payment accuracy reports, claims processing internal controls and most significantly the failure to follow-up on system errors and overpayments discovered through the claims payment accuracy testing. As a result of the significant deficiencies, testing of the payments made by the claims processing system was substantially expanded. In lieu of the normal test procedures, TDCI contracted with a claims consultant to perform a comprehensive medical claims overpayment review (See Section VII.D.).

D. Results of the Medical Claims Overpayment Review

On June 22, 2005, UAHC and the TennCare Bureau entered into a memorandum of understanding in which UAHC agreed to the following corrective measures regarding claims processing:

- UAHC submitted to an immediate and comprehensive, multi-year audit of all processed claims to be completed by the end of the first quarter of fiscal year ended June 30, 2006. UAHC will reimburse the state for all costs associated with this process. TDCI will issue a report by October 15, 2005.

- UAHC committed to full and immediate repayment of all overpayments documented as a result of this claims audit once complete. In recognition of the potential level of claims inaccuracies found on preliminary review by TDCI. UAHC agreed to immediately put into escrow a sum equivalent to 1% of all medical payments in the fiscal year ending June 30, 2005 or $2,300,000.

- UAHC committed to a follow-up comprehensive external audit of claims processing accuracy at the close of fiscal year June 30, 2006. If this audit

again reveals accuracy levels below the threshold minimum permitted by federal authorities, the Centers for Medicare and Medicaid Services, and TennCare contract with UAHC will be terminated.

TDCI contracted with a claims consultant to perform a medical claims overpayment review of UAHC beginning July 1, 2005. The primary focus of the review was to identify overpayment issues processed through UAHC's claims processing system during the no risk period for dates of service May 1, 2002, through June 30, 2005. Testing focused on overpayment issues previously identified by TDCI and UAHC's Internal Audit. Other overpayment issues were identified during the review and testing was expanded accordingly.

The claims consultant, TDCI, UAHC, and Vestica representatives held weekly conference calls to discuss the progress of the claims overpayment review from July 14, 2005, through October 13, 2005. The medical claims overpayment review report discusses in detail the methods utilized to determine overpayments. UAHC was provided a draft version of the report before release.

The medical claims overpayment review determined the following summary of total overpayments for the period May 2002 through June 2005:

A. Pricing Accuracy	$2,493,116.88
B. Payment Accuracy	1,312,798.71
C. Coordination of Benefits	188,459.80
D. Eligibility	126,313.33
E. Duplicates	1,388,848.67
F. Timeliness	5,687.38
Total	$5,515,224.77

The medical claims overpayment review identified additional issues beyond the errors noted by UAHC's internal audit. The following is a summary of the issues in which UAHC concurred with the claims consultant's findings. The complete discussion of findings and UAHC comments can be found in the medical claims overpayment review issued December 31, 2005 included as an Appendix to this report:

- Claims were overpaid where service lines included modifier 26.

- Service lines were overpaid based on provider contracted rates.

- Ambulance claims were overpaid because items such as medical supplies are being paid that should be included in a flat transportation rate per the contract, and mileage was not reimbursed at the contracted rate.

- Claims for a hospital provider were incorrectly paid because the contracted rate for emergency room claims was an all inclusive rate. Services such as MRI and CT scans were incorrectly paid outside of the all inclusive rate.

- Claims were incorrectly paid at an amount greater than billed charges.

- Cesarean section case rates were incorrectly applied because the contracted case rate includes the first four days instead of the first three days as applied.

- Claim service lines which were covered under capitation agreements were incorrectly paid fee-for-service to either the member's capitated group or to another capitated group based upon UAHC's business rules.

- Monthly PCP assignments data files were interpreted incorrectly resulting in payments for claims which should have paid zero under the terms of capitation agreements.

- Well baby claims with revenue codes of 170 or 171 covered under the mother's per diem or case rate were incorrectly paid fee-for-service.

- Per diem payments were incorrectly calculated.

- Where Medicare was primary on a claim and there was a deductible or coinsurance, coordination of benefits was not correctly considered when determining the payment due.

- Overpayments for facility claims occurred where the member was eligible for TennCare for a portion of an inpatient stay but not for the entire date span billed.

- Duplicate claims payments were identified for physician claims, inpatient claims, emergency room claims and interim billing payments.

- UAHC incorrectly added a service line with revenue code 191 to process claims when the days billed did not equal the days authorized. This procedure also caused the claims system logic to allow duplicate claims payments resulting in overpayments.

The Medical Overpayment Review confirmed significant deficiencies in claims processing previously identified by UAHC's Internal Audit as well as identified additional deficiencies.

Final Management's Comments to the Medical Claims Overpayment Review

UAHC Health Plan, Inc. accepts the agreed upon findings of this audit and the professional and courteous manner in which it was conducted. Although we may not concur on all findings, the audit was deemed to be fair and impartial. UAHC will continue to research and audit files identified by the auditor that were

not fully researched and or completed. Identified recoupments, adjustments etc. will be performed upon confirmed research of the outstanding claims.

UAHC does not concur with the final amount of overpaid claims to be recouped as submitted by the auditor. UAHC's findings were in-line and closer to the amounts originally reported by the auditor and submitted to the Plan.

UAHC has put processes in place to prevent and or identify errors for future claims processing. The audit has enlightened the Plan with regards to quality improvements needed in its claims processing procedures and oversight necessary for its third party claims vendor/subcontractor. Identified controls have been established and processes implemented.

UAHC has recouped 85% of the overpayments identified in the audit and will continue to recover all identified overpayments and errors. UAHC's goal is to recoup 95% of the identified overpayments by June 30, 2006. The Plan's Network remains strong and committed to the completion of the audit and has worked with us in recouping these funds timely.

TDCI's Recommendations

UAHC should continue to improve claims payment accuracy percentages. Monitoring of the claims processing subcontractor should be enhanced. Benefit rules and claims processing system logic should be consistently and correctly applied. UAHC should ensure that all fee tables and disbursement methodologies are accurately configured in Vestica's claims processing system. Current claims payment accuracy percentages indicate the medical claims overpayment review scheduled to begin July 1, 2006 is necessary.

Because all overpayments must be reimbursed to the TennCare Bureau, The TennCare Bureau must make the final decision of amounts to be reimbursed in instances where UAHC disputes the amount of overpayments identified in the medical claims overpayment review.

Management's Comments

UAHC disputes many of the findings by the auditor. UAHC has identified approximately $2.3 million of disputed findings and/or audit errors. Given the condensed timeline for the auditor to conduct analysis, many of the findings were not verified by reviewing the source claim documentation. At the request of TennCare, UAHC has engaged an outside accounting firm to review the disputed findings/audit errors as well as the items designated as 'not reviewed'. We strongly dispute TDCIs assertion that this audit has revealed deficiencies with CMS and TennCare's claims accuracy requirements and believe such statements to be unwarranted and premature for the following reasons:

- The audit has not been concluded. Many items were designated as not

reviewed

- The $5.5 million number mentioned above is somewhat distorted and misleading, since UAHC continues to dispute $2.3 million of the findings
- The dollar value of the overpayments must be evaluated in perspective of the dollar value of claims processed over the period of May 2002-June 2005, which was over $600 million. Identified overpayments to date are less than 1% of claims processed during the period

TDCI Rebuttal:

The previously released medical claims overpayment is included as an appendix to this exam report. The TennCare Bureau must make the final decision of amounts to be reimbursed in instances where UAHC disputes the amount of overpayments identified in the medical claims overpayment review.

E. Review of Vision Claims Processing

UAHC contracted with Block Vision to process routine vision claims during the examination period. UAHC contracts directly with vision providers.

1. Test Procedures for Vision Claims

TDCI requested data files of all payments by Block Vision for the period January 1, 2003 through April 31, 2005. TDCI selected for testing claims from the data files provided. The accuracy of vision claim payments were verified through cancelled checks, screen prints from the claims processing system, and compensation exhibits of the provider contract.

2. Results of Vision Claims Testing

The following deficiencies were noted in vision claims selected for testing:

a. For 45 claim service lines, TDCI could not verify the validity of the procedures codes reported on the data files provided by Block Vision.

- For 24 of the 45 claim service lines, Block indicated that the authorization number instead of the procedure code was provided in the data file.

- For 18 of the 45 claim service lines, Block indicated invalid procedure codes were entered.

- For 3 of the 45 claim service lines, the internet claims processing did not prohibit the entry of incorrect procedure codes by providers via internet.

b. For 51 claim service lines, TDCI found the procedure codes which reported medical evaluation office visits instead of vision services. Block responded:

- For 46 of the 51 claims, the claims were processed correctly as routine vision services because the ICD-9 (diagnosis) billed was routine in nature. Even if a provider bills with the E&M codes, as long as the ICD-9 billed is routine then the service is paid at the standard routine vision rate.

- For one of the 51 claims, the claim was processed and paid correctly given that the Primary ICD-9 code was for routine vision services.

- For four of the 51 claims, the claims were processed incorrectly because the ICD-9 code indicates that these were for medical services.

Management's Comments

As previously noted, UAHC notified TDCI on August 16, 2005, that Block Vision's Administrative Service Agreement had been cancelled. Vestica began processing vision claims with dates of service after the Block Vision termination.

VIII. REPORT OF OTHER FINDINGS AND ANALYSES – COMPLIANCE TESTING

A. Provider Complaints

The purpose for testing provider complaints is to determine if UAHC has developed adequate procedures to ensure that providers receive a timely response. The written policies and procedures concerning provider complaints were reviewed. Ten complaints were selected from UAHC's provider complaint log entitled "customer service report". UAHC responded to each of the complaints within 30 days.

B. Provider Manual

The provider manual outlines written guidelines to providers to assure that claims are processed accurately and timely. In addition, the provider manual informs providers of the correct procedures to follow in the event of a disputed claim. On November 3, 2004, UAHC submitted to TDCI a provider manual as a material modification to its certificate of authority. TDCI approved the provider manual on November 10, 2004.

C. Provider Agreements

Agreements between an HMO and medical providers represent operational documents to be prior approved by TDCI in order for TDCI to grant a certificate of authority for a company to operate as an HMO as provided by Tenn. Code Ann. § 56-32-203(b)(4). The HMO is required to file a notice and obtain the Commissioner's approval prior to any material modification of the operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1). Additionally, the TennCare

Bureau has defined through contract with the HMO minimum language requirements to be contained in the agreement between the HMO and medical providers. These minimum contract language requirements include but are not limited to: standards of care, assurance of TennCare enrollee's rights, compliance with all Federal and state laws and regulations, and prompt and accurate payment from the HMO to the medical provider.

Per Section 2-9. of the CRA between UAHC and the TennCare Bureau, all template provider agreements and revisions thereto must be approved in advance by the TennCare Division, Department of Commerce and Insurance, in accordance with statutes regarding the approval of an HMO's certificate of authority and any material modification thereof. Additionally, Section 2-18. of the CRA requires that all provider agreements executed by UAHC shall at a minimum meet the 44 current requirements listed in Section 2-18.

TDCI selected three provider contracts to determine compliance with Section 2-18. of the CRA. In addition, the contracts were reviewed to determine if they were previously submitted to TDCI for approval. The testing revealed:

- For one of the provider contracts for a hospital provider, UAHC had submitted the contract to TDCI for prior approval.

- For two of the provider contracts, the contracts were executed with signatures dates August 2001 and October 2001. Both contracts included unsigned amendments entitled Exhibit 11 and Exhibit 12. Exhibit 11 included required changes based upon Section 2-18. of the CRA effective July 1, 2003. Exhibit 12 included required changes based upon Section 2-18. of the CRA effective January 1, 2005. Neither amendments was submitted to TDCI for prior approval as a material modification to UAHC's certificate of authority as required by Tenn. Code Ann. § 56-32-203(c)(1). UAHC should submit any amendments to approved provider contract templates for prior approval by TDCI.

  Management's Comments

  UAHC concurs with this finding and will submit all future contract amendments and exhibits to TDCI for approval as material modifications. The approved provider agreement template was for use for the overall plan and was not directed to one provider. In the Plan's submission to TDCI for approval, a particular provider was named in the document.

D. Subcontracts

HMOs are required to file a notice and obtain the commissioner's approval prior to any material modification of operational documents in accordance with Tenn. Code Ann. § 56-32-203(c)(1).

1. Subcontract Prior Approval

   - The subcontract for Vestica (formerly Doral USA) was submitted by UAHC to TDCI for prior approval. TDCI approved the subcontract on May 8, 2001

   - During 2003, the Block Vision subcontract was submitted to TDCI by UAHC for prior approval. A letter from TDCI on February 23, 2003, advised UAHC that their submission of the material modification was deficient. No response was made to correct the deficiencies noted. Subsequent to examination fieldwork on August 16, 2005, UAHC notified TDCI that Block Vision's Administrative Service Agreement had been cancelled. Vestica, the subcontractor for medical claims processing, began processing vision claims with dates of service after the Block Vision termination.

   Management's Comments

   UAHC and Block (subcontractor) were unable to negotiate the terms of a modified agreement that would have included all of the deficiencies noted in TDCI's review. The Subcontractor was requesting a rate increase and was not willing to sign a new agreement with the modified language. Thereby, UAHC had nothing to resubmit to TDCI. Had a new agreement been reached, the Plan would then have submitted a revised document to TDCI for approval with the noted revisions. The subcontractor subsequently termed the service agreement as a result of the negations, at which time UAHC notified TDCI immediately.

2. Monitoring of Subcontractors

   UAHC is responsible for the administration and management of all aspects of the CRA including performance by subcontractors. No subcontract or other delegation of responsibility terminates or reduces the legal responsibility of UAHC to TennCare to assure that all activities under the CRA are carried out.

   The prior examination of UAHC by TDCI noted that UAHC should improve the monitoring efforts of its subcontractor for claims processing services. UAHC concurred. As noted in this report, UAHC did hire an internal auditor since the previous examination, but UAHC's monitoring efforts of subcontractor's remains deficient.

   Both of the subcontractors for claims processing experienced significant deficiencies. Claims payment accuracy percentage failed to meet CRA requirements of 97%. UAHC internal audits and the medical claims overpayment review noted material overpayments as a result of the claims processing system payment logic. Furthermore, vision claims were not

processed timely in accordance with Tenn. Code Ann. § 56-32-226(b)(1).

At a minimum, TDCI recommends that UAHC adopt the following procedures to improve the monitoring of subcontractors:

- When the internal auditor notes deficiencies by the subcontractor, testing should be expanded to determine if other claims paid have applied similar incorrect system payment logic.

- The testing for claims payment accuracy by UAHC's internal auditor did not identify all of the deficiencies noted by the claims consultant. To ensure that the internal auditor does identify deficiencies in the future, the internal audit department should supplement claims payment accuracy testing with similar computerized audit techniques utilized by the claims consultant. These techniques can be designed to search for payment errors such as duplicate payments made by the subcontractor. Several auditing software packages are available by outside vendors. A key to applying computerized audit techniques is to have an accurate data warehouse. TDCI found that UAHC's data warehouse of previously processed claims was incomplete since it did not to include adjusted claims.

- UAHC should clearly document the business rules for the subcontractor to utilize in processing claims. During the medical claims overpayment review, it was discovered the subcontractor was applying old business rules previously supplied by UAHC.

- UAHC should complete an audit of all fee tables loaded in the claims processing system. During the medical claims overpayment review, errors continued to be found in the fee tables established in the claims processing system as compared to contracted provider rates. In many instances, the subcontractor relied upon emails sent from UAHC officials to determine the appropriate payment rate.

- UAHC should gain a clear understanding of the claim processing system utilized by the subcontractor. At the beginning of fieldwork, UAHC's only access to the subcontractor's claims processing system was through a limited web inquiry. The web inquiry was insufficient since it did not allow UAHC to review relevant modules of the subcontractor's claims processing system including member eligibility, provider maintenance, authorization system, fee tables and other processing modules. During the medical claims overpayment review, the claims consultant and UAHC both gained in inquiry mode the necessary access to the subcontractor's claims processing system.

  Management's Comments

> All of the above noted recommendations have been put into place operationally and are being utilized in the current monitoring of the claims subcontractor.

E. Non-discrimination

Section 2-24. of the CRA requires UAHC to demonstrate compliance with Federal and State regulations of the Title VI of the 1964 Civil Rights Act, Section 504 of the Rehabilitation Act of 1973, Title II of American Disabilities Act of 1990, the Age Discrimination Act of 1975 and Omnibus Budget Reconciliation Act of 1981. Based on discussions with various UAHC staff and a review of policies and related supporting documentation, UAHC was in compliance with the reporting requirements of Section 2-24. of the CRA.

F. Stabilization

Section 3-10.h.2.(a) of Amendment 2 of UAHC's CRA requires UAHC to comply with the following:

> The CONTRACTOR shall reimburse providers according to reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures in effect as of April 16, 2002, for covered services as defined in Section 3-10.2.(j), unless otherwise directed by TENNCARE, with funds deposited by the TENNCARE, with funds deposited by the State for such reimbursement by the CONTRACTOR to the provider.

UAHC's management has confirmed compliance with the stabilization requirements. During testing of financial, claims processing, and provider contracts, no deviations to the stabilization requirements were noted by TDCI.

G. HMO Holding Companies

Effective January 1, 2000, all HMOs were required to comply with Tenn. Code Ann., title 56, Chapter 11, Part 2 – the Insurance Holding Company System Act of 1986. Tenn. Code Ann. § 56-11-205 states, "Every insurer and every health maintenance organization which is authorized to do business in this state and which is a member of an insurance holding company system or health maintenance organization holding company system shall register with the commissioner…" With the exception of the tax sharing agreement previously discussed in Section VI.F.of this report, UAHC has complied with this statute. The allocation of income tax expense on a consolidated basis in 2004 should have been reported in the 2004 Holding Company registration due April 2005. UAHC should include the tax sharing agreement in the 2005 Holding Company registration due April 30, 2006 (See Section VI.F.).

H. Internal Audit Function

The importance of an internal audit function is to provide an independent review and evaluation of the accuracy of financial recordkeeping, the reliability and integrity of information, the adequacy of internal controls, and compliance with applicable laws, policies, procedures, and regulations. An internal audit function is responsible for performing audits to ensure the economical and efficient use of resources by all departments to accomplish the objectives and goals for the operations of the department. The internal audit department should report directly to the board of directors so the department can maintain its independence and objectivity.

The Institute of Internal Auditors has issued international standards for the professional practice of internal auditing. Those standards state, "The internal auditor should have sufficient knowledge of fraud but is not expected to have the expertise to of a person whose primary responsibility is detecting and investigating fraud." Additionally the standards state, "Internal auditors should have knowledge of key information technology risks and controls and available technology-based audit techniques to perform their assigned work". The internal audit department "should report to a level within the organization that allows the internal audit activity to fulfill its responsibilities."

Subsequent to the examination period effective July 1, 2005, Section 2.9. of the CRA was amended to require UAHC to appoint specific staff to an internal audit department that shall report directly to the board of directors or appropriate level of management. The amendment also requires the submission of an annual Audit Plan to TennCare.

The prior examination report noted in a finding that UAHC did not have internal audit function. UAHC did not concur with the finding. Since the prior examination, UAHC did hire an internal auditor in calendar year 2004. The internal auditor performed the testing for the claims payment accuracy reporting. The reports by the internal auditor did find deficiencies in the claims payment by the claims processing subcontractor. The deficiencies by UAHC's internal auditor revealed that most of the errors reflected improper establishment of the claims processing system payment logic. This included the inaccurate application of UAHC's business rules and payments for specific procedure codes not in agreement with agreed to compensation in provider contracts. These deficiencies had not been discovered previously when the claims processing subcontractor was preparing the claims payments accuracy reports for UAHC. With the hiring of the internal auditor, significant improvements have occurred at UAHC in identifying claims processing issues.

The following deficiencies remain for UAHCs internal audit function as of the end of fieldwork:

- Although the internal auditor noted significant deficiencies in claims payment by the claims processing subcontractor, UAHC did not expand testing to determine if other claims paid have applied similar incorrect system payment logic. As a result of this failure to follow-up on incorrect system payment logic, material overpayments occurred. UAHC should establish procedures to carefully consider noted errors by the internal auditor and appropriate

research if others claims were incorrectly processed in the same manner.

- As previously noted in Section VII.B.2. of this report, the procedures to prepare claims payment accuracy reports were deficient because of inadequate sample selection methods and the failure to maintain a sufficient audit trail of attributes tested.

- The internal auditor should also perform focused reviews to determine UAHC's compliance with CRA requirements including the conflict of interest requirements.

Management's Comments

As previously noted UAHC has expanded the internal audit procedures to:

- Consider noted errors by the internal auditor and appropriate research if others claims were incorrectly processed in the same manner.
- Correct the sample selection methods and is now maintaining a sufficient audit trail of attributes tested.
- Internal auditor along with the compliance manager is now performing focused reviews to determine UAHC's compliance with CRA requirements including the conflict of interest requirements.

I. Conflict of Interest

Sections 4-7. of the CRA warrants that no part of the amount provided by TennCare shall be paid directly or indirectly to any officer or employee of the State of Tennessee as wages, compensation, or gifts in exchange for acting as officer, agent, employee, subcontractor, or consultant to UAHC in connection with any work contemplated or performed relative to this Agreement unless otherwise authorized by the Commissioner, Tennessee Department of Finance and Administration.

Subsequent to the examination period, conflict of interest requirements of the CRA were expanded to require an annual filing of a TennCare Disclosure of Lobbying Activities Form certifying that the MCO is in compliance with all state and federal laws relating to conflicts of interest and lobbying.

Failure to comply with conflicts of interest requirements of the CRA could result in liquidated damages in the amount of one-hundred ten percent (110%) of the total amount of compensation that was paid inappropriately and may be considered a breach of the CRA.

The MCO is responsible for maintaining adequate internal controls to detect and prevent conflicts of interest from occurring at all levels of the organization and for

including the substance of this clause in all agreements, subcontracts, provider agreements, and any and all agreements that result from the CRA.

Since November 2002, UAHC has been the sole source of revenue for both the management company, United American Tennessee, and the ultimate parent, United American Detroit.

In March 2005, the former Vice President and General Counsel for UAHC, filed a lawsuit against UAHC, United American Tennessee and United American Detroit alleging wrongful discharge in violation of the Tennessee Public Protection Act and the Tennessee common law of whistle blower retaliation. The former employee was also UAHC's compliance officer, having the responsibility of overseeing UAHC's compliance with state and federal law requirements. Specifically, the lawsuit alleges that the employee was fired because she "opposed and refused to remain silent about or participate in what she had a good faith belief were illegal acts and/or violations of state regulations and/or public policy."

As a result of several media reports that linked former State Senator John Ford to UAHC, on February 10, 2005, TDCI sent a letter to Osbie Howard, the former President and CEO of UAHC, asking him to describe the nature of business relationships between UAHC and Managed Care Services Group and Managed Care Services Group I, companies reported as affiliated with former State Senator John Ford. On or around February 15, 2005, Mr. Howard responded to the Division that UAHC did not have any business relationships with Managed Care Services Group or Managed Care Services Group I. On February 24, 2005, the TennCare Bureau requested that UAHC review all contracts (including subcontracts and provider agreements) for compliance with conflict of interest provisions in the TennCare Contractor Risk Agreement and that it "provide a copy of any contracts that did not comply and an accounting of any payments made that were funded directly or indirectly with funds from TennCare." On March 1, 2005, UAHC replied that all contracts were in compliance. On April 15, 2005, William C. Brooks, President, CEO and Chairman of United American Detroit issued a press release stating that beginning in 2001, United American Detroit contracted with former State Senator John Ford for consulting services to "explore expansion of its business to other southern states beyond Tennessee…" The statement further indicated that United American Detroit terminated this contract on March 11, 2005. Brooks' statement further noted that he was "recently made aware of" a relationship between Osbie Howard and Managed Care Services Group, the company affiliated with former State Senator John Ford. The statement finally noted the immediate retirement of Osbie Howard as CEO of UAHC and resignation from all executive officer, director and other positions with UAHC, United American Tennessee, and United American Detroit.

On April 20, 2005, TDCI issued a notification of administration supervision because TDCI determined UAHC to be in a hazardous condition based upon the apparent untrustworthiness of former management of UAHC and violations of the conflict of interest provisions of the CRA. Additionally, TDCI initiated an examination of the

books and records of UAHC. During administrative supervision management retains control of the operations but certain transactions require prior approval by the Commissioner or designated representative. The notice of administrative supervision expired on December 31, 2005.

As previously mentioned, effective May 1, 2002, the CRA with UAHC was amended for UAHC to temporarily operate under a no risk agreement. UAHC agreed to reimburse providers for the provision of covered services in accordance with reimbursement rates, reimbursement policies and procedures, and medical management policies and procedures as they existed April 16, 2002, unless such a change received approval in advance by the TennCare Bureau. Before April 16, 2002, UAHC held a reinsurance policy with Oseman Insurance Agency. UAHC was required to maintain this policy during stabilization. The reinsurance premiums were funded by TennCare and recoveries from this policy were reimbursed to TennCare. In 2005, UAHC and TennCare became aware that former State Senator John Ford was an insurance agent for Oseman Insurance Agency. On June 17, 2005, the TennCare Bureau requested any MCO with reinsurance policies to terminate such policies by July 31, 2005. UAHC cancelled the reinsurance policy accordingly.

On June 22, 2005, UAHC and the TennCare Bureau entered into a memorandum of understanding in which UAHC agreed to the following:

- Immediate escrow of the full sum made to former State Senator John Ford which total $420,500 as per UAHC legal counsel's letter of May 31, 2005. This escrow agreement was sent to UAHC on June 27, 2005.

The escrow agreement states:

- UAHC shall escrow with TennCare the sum of $420,500. In depositing such amount into escrow, UAHC specifically denies that it has any way breached the Contract and affirms that it is making the payment in good faith for the security of TennCare. TennCare specifically acknowledges that it has not asserted any claims against UAHC, and it is not TennCare's intent to imply or suggest that the establishment of the escrow is evidence of or should be construed as an admission of any wrongdoing by UAHC. TennCare further acknowledges that the deposit is not required under the terms of the Contract.

- If litigation is pursued by either party, both parties agree that the escrow deposit account shall remain in full force and effect until such time that a final judgment has been rendered by a court of competent jurisdiction and the conclusion of an appeal, in any.

The only HMO administered by United American Tennessee is UAHC. Compensation by UAHC to United American Tennessee per the management agreement is 90% of the administrative fee payments received from TennCare. As of November 2002, UAHC is the only HMO that is controlled or administered by United American Detroit, the ultimate parent of the plan and the management

company. During calendar year 2004, United American Tennessee transferred $4,550,000 to United American Detroit.

TDCI recommends that UAHC, United American Tennessee and United American Detroit implement the following procedures to enhance compliance with the CRA including the conflict of interest requirements:

- Since the only HMO controlled by United American Detroit is UAHC, the TennCare plan, members of the board of directors and officers of United American Detroit should be held to the same annual reaffirmation of the code of conduct disclosures required by employees of the management company. The directors and officers of United American Detroit have the same responsibility as United American Tennessee employees to ensure compliance with all of the terms of the CRA.

- This examination report included multiple deficiencies in TennCare operations including overpayment of federal and state dollars and failures in the monitoring of subcontractors. Oversight by the board of directors and the officers of UAHC, United American Tennessee, and United American Detroit should focus on the correction of deficiencies in TennCare operations.

- As previously noted the internal audit department should perform focused reviews to determine UAHC's compliance with CRA requirements including the conflict of interest requirements. Through internal audit, the board of directors of UAHC, United American Tennessee, and United American Detroit will ensure that management adheres to internal controls established.

  Management's Comments

  - Members of the board of directors and officers of United American Detroit are now held to the same annual reaffirmation of the code of conduct disclosures required by employees of the management company. The directors and officers of United American Detroit have the same responsibility as United American Tennessee employees to ensure compliance with all of the terms of the CRA.

  - Oversight by the board of directors and the officers of UAHC, United American Tennessee, and United American Detroit are now comprehensively focused on the correction of deficiencies in the TennCare operations.

  - As previously noted the internal audit department now performs focused reviews to determine UAHC's compliance with CRA requirements including the conflict of interest requirements. Through internal audits, the board of directors of UAHC, United American Tennessee, and United American Detroit ensures that management adheres to the established internal controls as well as to meet Sarbanes-Oxley compliance.

As of the release of this examination report, investigations of payments by United American Detroit to former State Senator John Ford and possible violation of conflict of interest requirements of the CRA has not been concluded. The escrow deposit for $420,500 remains in effect. The TennCare Bureau has the right to avail itself of any and all remedies afforded by state and federal law and the CRA if violations are ultimately determined to exist.

The examiners hereby acknowledge the courtesy and cooperation of the officers and employees of UAHC.

APPENDIX

MEDICAL CLAIMS OVERPAYMENT REVIEW

OF

UAHC OF TENNESSEE, INC.

FOR THE PERIOD

MAY 1, 2002 THROUGH JUNE 30, 2005

Cynthia Harris, CPA
Contracted Claims Consultant

To: J.D. Hickey, Deputy Commissioner
Department of Finance and Administration, Bureau of TennCare

Via: Lisa R. Jordan, CPA, Assistant Commissionner
Department of Commerce and Insurance

John R. Mattingly, CPA, TennCare Examinations Director
Department of Commerce and Insurance

CC: Paula A. Flowers, Commissioner
Department of Commerce and Insurance

Paul Eggers, CPA
Administrative Supervisor

Date: December 18, 2005

Re: Medical Claims Overpayment Review of UAHC Health Plan of Tennessee, Inc., for the period May 1, 2002 through June 30, 2005

REVIEW SCOPE AND PROCEDURES

The Department of Commerce and Insurance TennCare Oversight Division (TDCI) had contracted me to perform a medical claims overpayment review of UAHC Health Plan of Tennessee, Inc. (UAHC) beginning on July 1, 2005. The primary focus of the review was to identify overpayment issues processed through UAHC's claims processing system during the no-risk period for dates of service May 1, 2002 through June 30, 2005. The overpayment issues identified through a memorandum by TDCI on June 13, 2005, to you describing the current status and deficiencies in UAHC's claims processing operations were the foundation of this medical claims overpayment review. Other overpayment issues were identified during this review and testing was expanded accordingly.

It is important to note that this review was designed to identify claims processing deficiencies that could result in material overpayment of medical claims. Other claims payment errors may exist that were not detected during this review.

As noted in the TDCI June 13, 2005 memorandum, UAHC's management company subcontracts with Vestica Healthcare (Vestica) for the processing of medical claims. For the purposes of this review, UAHC/Vestica provided electronic claims data files for all processed claims for the review period of May

1, 2002 through June 30, 2005, as described in the Memorandum of Understanding dated June 22, 2005 between UAHC and the TennCare Bureau. In order to perform the review, UAHC was also asked to provide fee tables, business rules, PCP assignment tables, and online access to the Vestica claims processing system. Initially, UAHC provided claims data that included paid dates of January 1, 2005 through June 30, 2005.

A detailed description of the review procedures and the findings in each category are outlined below. Findings are divided into physician and facility categories. The physician category includes all claims billed on a HCFA1500 claim form, and the facility category includes all claims billed on a UB92 claim form. Weekly conference calls were held between July 14, 2005, and October 13, 2005, except for the week of August 25th, with personnel from TDCI, UAHC, Vestica, UAHC Administrative Supervisor Paul Eggers, and me to discuss the data, potential findings, UAHC's policies and procedures, and the status of UAHC and Vestica's research once potential overpayments were submitted for review to the plan.

After identifying overpayments in claims paid during the time period January 2005 through June 2005, the review expanded to cover paid dates May 2002 through December 2004 once that data was received from UAHC. Due to time constraints, only the significant potential overpayment issues were identified back to May 2002 and given to UAHC to research.

If the TennCare Bureau requires UAHC to test and report on the claims issues I was not able to test for the period May 2002 through December 2004, the results of UAHC's expanded efforts could be re-examined during the claims review to be completed at the end of the fiscal year June 2006 per the Memorandum of Understanding upon the TennCare Bureau's request.

OVERPAYMENTS IDENTIFIED

The following is a summary of total overpayments discovered during the review for the period May 2002 through June 2005:

A. Pricing Accuracy	$2,493,116.88
B. Payment Accuracy	1,312,798.71
C. Coordination of Benefits	188,459.80
D. Eligibility	126,313.33
E. Duplicates	1,388,848.67
F. Timeliness	5,687.38
Total	$5,515,224.77

Attachment 1 provides a detailed listing by period reviewed of the overpayments UAHC has agreed to recoup in each category for 2005 as well as the more

significant overpayments researched and agreed upon by UAHC paid between May 2002 and December 2004.

Attachment 1 also provides Vestica's and/or UAHC's response as to how the overpayment errors occurred and what steps have been taken to prevent the overpayments in the future.

RECOUPMENT EFFORTS

UAHC and Vestica began recouping payments that were identified in the review during August 2005 and are still organizing recoupment efforts as of the date of this report. Data has not been requested beyond June 30, 2005 paid dates; therefore, the accuracy of the recoupment process has not been verified. TDCI has requested that UAHC should report monthly the status of recoupment efforts to TDCI and the TennCare Bureau. If requested by the TennCare Bureau, the accuracy of these recoupment efforts can be tested with the follow-up review at the close of fiscal year ending June 30, 2006, described in the Memorandum of Understanding.

RESULTS OF DETAILED TESTING PROCEDURES

A. Pricing Accuracy

1. Physician Claims

a. The majority of UAHC's physicians are contracted at either 60% of the 2001 Medicare fee schedule or 85% of the 2001 Medicare fee schedule. The rate for non-contracted physicians is 60% of the 2001 Medicare fee schedule. A few physicians are paid at a percent of billed charges or have procedure specific rates in their contract with UAHC. The fee tables established by UAHC do not reflect the facility Medicare weights for physician services. Instead, the non-facility weights are used for all procedures, regardless of where the service was provided.

   The percent paid of the 2001 Medicare rate was calculated for all physician claim lines paid if there was a Medicare allowable for the procedure. The percent paid was compared to the fee table description provided in the data file (i.e. "60% of 2001 Medicare Contracted Providers) to determine if procedures were being paid outside the contracted/non-contracted rate. A sample of contracts was reviewed and compared to the fee table description in the data file to ensure the contracted rate was loaded correctly in UAHC's claims processing system.

As identified in the examination conducted by TDCI, UAHC has not been paying the professional component of a procedure (modifier 26) based on the 2001 Medicare fee schedule. A business rule was established by the company on January 31, 2001, which stated 40% of the global rate for a procedure would be paid when a procedure was billed with a 26 modifier. This pricing is higher than the 2001 Medicare fee schedule. All claim lines paid with a 26 modifier were reviewed to determine the difference between the contracted rate and the amount paid per UAHC's business rule. The review revealed that the business rule, instead of the contracted percent of the 2001 Medicare fee schedule, was applied only to one single contracted medical group. Outlined below is an example of the difference in payment using the two payment methodologies:

Example:
Procedure 70551- 26 is the interpretation of a MRI. The 2001 Medicare rate is $76.71.

The 2001 Medicare global rate for procedure 70551 is $474.80 which includes performing the MRI and interpreting the results.

The medical group's contracted rate is 85% of the 2001 Medicare fee schedule. Applying 85% to the rate of $76.71 results in payment of $65.20.

The business rule has been applied using 40% of 85% of the 2001 Medicare fee schedule for the global code. Applying the UAHC business rule of paying 40% of the global fee results in payment of $161.43.

During the period January 1, 2005 through June 30, 2005, procedure 70551-26 was paid 29 times at the contracted rate of $65.20 to the medical group, and 88 times at the rate of $161.43 which is 40% of 85% of the 2001 Medicare fee schedule for the global code.

Application of the business rule has resulted in payments for certain procedures being as high as 532% of the 2001 Medicare rate. For claim lines that did not pay at the appropriate percentage of the 2001 Medicare fee schedule, the difference between the actual payment and the 2001 Medicare rate for the medical group is an overpayment of $120,170.29 for the six months ended June 30, 2005.

UAHC Response:
UAHC concurs with these findings*. In May 2005 UAHC updated the fee tables and the business rules for this specific provider to be reimbursed under the 2001 Medicare Rules for all Modifiers including 26. Provider was previously reimbursed using an old OmniCare fee schedule and business rules. As the auditor states, UAHC repealed the business rule related to the 26 modifier so that claims after May 13, 2005 are processed in accordance with the Medicare modifier rules, and the fee table for this provider was updated to Medicare 2001.*

This overpayment was also calculated for the period May 2002 through December 2004. Refer to Attachment 1 for overpayment amounts.

As of May 13, 2005, UAHC repealed the business rule related to the 26 modifier so that claims after this date are correctly processed with the 26 modifier.

b. When identifying the Medicare rate for claim lines billed with a 26 modifier, it was discovered there is not a Medicare allowable for many of the claim lines billed with the 26 modifier. The majority of these claims were paid to one particular pathology group. The provider has been paid $188,752.98 when billing for an interpretation for 194 different lab procedures for which there is no Medicare allowable. The 26 modifier has been billed with basic lab procedures such as procedure 80048 for basis metabolic panel and procedure 80053 for comprehensive metabolic panel. Also, in many cases, the member was at an inpatient facility when the service was provided, and the hospital has billed the global code. Per UAHC, this provider is under investigation by the Tennessee Bureau of Investigation (TBI). UAHC currently does not intend to recoup any monies from this provider while the investigation by TBI continues.

UAHC Response:
UAHC concurs with this statement*. This Pathology Group is under investigation by TBI for using Modifier - 26 for procedures that do not require interpretation. Once the investigation is complete, the Plan will work with TBI on how best to recoup any payments made in error. The Provider is challenging the findings of the TBI audit. The issue is still in question as to whether or not the claims were billed improperly using the modifier 26.*

This particular laboratory provider does have an agreement with the hospital that allows the pathology group (provider) to bill for Medicare Part A services. The hospital does not bill for this service and only one provider is paid for the service. This Provider does have a specific fee

schedule included in their contract for Medicare Part A Services and the 26 modifier. If the provider is billing for Medicare Part A, inpatient services, the auditor would not have found a Medicare Part A allowable. The Provider was reimbursed for these services utilizing the established fee schedule that has been in place since 2000. UAHC is waiting the outcome of the TBI investigation, and will proceed accordingly for any due recoveries.

c. In addition to the 26-modifier issue, two procedures consistently were priced at amounts higher than the contracted/non-contracted rate. The Medicare code for venipuncture services (blood draw) for 2001 was G0001, and the Medicare rate was $3. UAHC has paid providers for venipuncture services under procedure 36415, and since there was not a Medicare allowable for this procedure until 2005, UAHC established the rate of $6.35. Consequently, this procedure has been paying between 100% and 265% of the 2001 Medicare allowable for venipuncture services. Also, the 2001 Medicare rate for procedure 88142 for cytopathology, cervical or vaginal is $28. The rate was loaded in the fee tables incorrectly at $29.40 in 2002. Vestica stated the rate was corrected in May 2005. The overpayment has been approximately $.85 - $1.20 per procedure, depending on the provider's rate. UAHC does not intend to recoup monies for these two procedures. An overpayment amount was not calculated for materiality purposes for these two procedures.

UAHC Response:
UAHC concurs with this statement*. UAHC established rates for certain codes for which Medicare does not have pricing. Blood drawing fee 36415 is one of the codes. UAHC established a set reimbursement for most providers for this code. Non-contracted providers were paid the lower rate. In May 2005 the Plan decided to put all providers under one scheduled reimbursement for this code.*

d. A provider contract was requested because testing found that claims were paying at inconsistent rates for this provider. Some claim lines were paying at 60% of the 2001 Medicare rate and others at 85% of the 2001 Medicare rate. Upon review of the contract terms, the provider should be reimbursed at 60% of the 2001 Medicare rate unless the service provided is an Early and Periodic Screening, Diagnosis and Treatment ("EPSDT") service. For EPSDT, reimbursement should be at 85% of the 2001 Medicare rate. All of the provider's claims were tested to determine if only EPSDT procedures were paying at the higher rate. EPSDT procedures were identified by the diagnosis and/or procedure codes billed. It was determined age restrictions were not set up in the claims processing system for certain

procedures. For example, procedure 99392 is to be billed for a preventive visit for a child between the age of one and four years. UAHC has paid this code in 2005 for persons up to the age of thirty-two and has paid at the rate of 85% of the 2001 Medicare rate simply because the code is an EPSDT procedure code. The lack of age restrictions on certain procedures allows procedures to pay that should not pay, and claims will be overpaid or underpaid when the correct procedure code is not billed. The review identified claim lines as overpaid to the provider if the age of the member did not fall in the age range identified by the procedure or if an EPSDT procedure was paid at 85% of the 2001 Medicare rate and the member was 21 years of age or older. UAHC agreed to recoup payments made in error due to the lack of age restrictions in the claims processing system but stated the intent behind the provider's contract was that EPSDT would be provided to all members at 85% of the 2001 Medicare rate, not just to members under 21 years of age. UAHC intends to recoup $20,155.88, however, the provider will be allowed to resubmit with the correct procedure code, and UAHC will lift the timely filing requirement for these particular claims.

UAHC Response:
UAHC does not concur with these findings. *The Plan does not agree with the Auditor's interpretation of the contracts or the CRA as outlined in Section 2-3.a.3. for Preventative Services. These services are applicable up to age 65. Specific reimbursement is established for each age category @ 85% of Medicare 2001. The auditor's interpretation is that only EPSDT services should be paid at the 85%. We disagree. Some lab fees and age-restricted codes were processed and paid incorrectly. There were several reasons for the error, which include instances where the mother's information was used to pay claims for newborn services within the first 30 days and thereby created the inappropriate age difference for the claim. UAHC follows the timely appeals process and has not waived any provisions for providers that were paid in error for these recoupments*.

Rebuttal:
Per the Contractor Risk Agreement (CRA), Section 2-3.u, "EPSDT Services means early and periodic screening, diagnosis and treatment of enrollees under age 21…" The TennCare Bureau is requested to provide its interpretation of the provider contract language in question.

During the audit, UAHC indicated if the provider was paid on an inappropriate billing for a member due to age, the payment would be recouped, and the timely filing requirement would be lifted for a corrected claim because of the time that has lapsed between payment

and the recoupment. This does not relate to claims billed for a baby using the mother's identification number.

e. Pricing verification could not be determined for all procedures because there is not a Medicare allowable for all procedures billed. UAHC has established rates for certain procedures for which there is not a Medicare allowable. For instance, Medicare does not pay for procedure 99000, specimen handling, but rather bundles the payment with the lab or pathology procedure billed. UAHC established the rate of $8.26 in 2001 for this procedure.

UAHC Response:
UAHC concurs with this statement. *While UAHC utilizes the majority of Medicare Guidelines, it is not always possible. Medicare does not have rules, guidelines or pricing for all CPT, HCPCS codes and or services allowed as a benefit or service by a Medicaid Program, especially TennCare. With that, rules and guidelines must be established by the Plan.*

f. A sampling of ambulance claims revealed ambulance claims were not being paid in accordance with contracted rates. After reviewing all ambulance claims paid during the six months ended June 30, 2005, it was determined approximately $182,950.12 has been overpaid because items such as medical supplies are being paid that should be included in a flat transportation rate per the contract, and mileage is not being reimbursed at the contracted rate. In addition, UAHC implemented a policy one month prior to this report to not pay non-contracted ambulance providers unless a special agreement was negotiated with the provider. Until last month, UAHC was paying non-contracted ambulance providers, and the rates paid these providers have not been reviewed.

UAHC Response:
UAHC concurs with this finding. *UAHC has initiated recoupment activity as indicated by the auditor. Fee schedule, pricing, policy and procedure changes have been implemented to correct all errors identified during the audit.*

2. Facility Claims

a. A hospital provider contract was amended by UAHC effective March 1, 2005. Prior to March 1, 2005, there was a rate of reimbursement for each level of emergency room care provided and, in addition, there were specific rates for MRIs and CT Scans. Effective March 1, 2005, the case rates for each level of emergency room care were all

inclusive. When the new rates were loaded in the claims processing system, the rates for the services previously provided outside the case rate continued to be paid. This resulted in $16,438.76 in overpayments by the end of June 2005.

UAHC Response:
UAHC concurs with this statement. *West Tennessee Healthcare's contractual rates changed in April 2005. There was some confusion regarding the effective date of the new contract, which resulted in the overpayments for ER claims. All amounts for these overpayments have been recouped.*

b. When claims are billed at an amount less than UAHC's allowed amount, UAHC's policy is to pay the lesser of billed charges or allowed payment. For 51 facility claims paid during the six month period ended June 30, 2005, the lesser than logic was not implemented which resulted in $74,888.99 being paid above billed charges. This amount does not include refunds already submitted by providers.

UAHC Response:
UAHC concurs with the statement. *Claims were paid based on contracted per-diem amount, which sometimes exceeded the amount billed. Edits have been placed in the system for all claims to be paid on the lesser of billed logic.*

This overpayment was also calculated for the period May 2002 through December 2004. Refer to Attachment 1 for overpayment amounts.

UAHC Response:
May 2002 through December 2003 files will be investigated and researched for identified possible overpayments. The Plan will report and process the outcome of our findings. The amount reported for the time period of May 2002 and 2003 are estimates and need to be researched for accuracy before any recoupments can be made.

Some of the identified claims were for transplants whereby the facility and professional claims were combined and paid to the facility. The facility claim under review appears to be overpaid, but the professional claims were zeroed out and paid in combination with the facility claim. Research will be performed to identify and correct any errors or overpaid claims.

c. Manual review of some obstetric claims paid to a hospital revealed rates for C-section deliveries were set up incorrectly in the claims processing system. The provider is contracted with a C-section case

rate of $3,520 for the first four days of stay, with each outlier day at $550. The case rate was loaded in the claims system as a three-day case rate, with each outlier day at $550. As a result, any C-section claim with more than a three day stay has been overpaid by one outlier day, or $550. Vestica has initiated a review to identify all overpayments for the past 18 months.

UAHC Response:
UAHC concurs with this finding. *These funds have been recouped and the edit for the fee schedule has been reloaded for this hospital-facility for Cesarean-section case rates.*

d. Significant amounts of positive adjustments were noted as being made to claims previously paid. Adjusted payments over $5,000 were reviewed for pricing accuracy. Vestica/UAHC responded that most of these adjustments were correct. Some adjustments were made for implants billed on an inpatient hospital claim. The adjustments were made to a hospital provider whose contract contains only per diems for an inpatient hospital stay yet UAHC negotiates the reimbursement for implants on a case by case basis. Also, many of the adjustments were made because payments were originally made at UAHC's rate for non-contracted hospitals yet there were one time agreements which negotiated payment in excess of the standard non-contracted hospital rate. Adjustments were identified that raised the average hospital rate to more than $11,000 per day. For the six months ended June 30, 2005, $27,175 should be recouped for erroneous adjustments.

UAHC Response:
UAHC does not concur with these findings. *Most hospital-facility contracts allow for the reimbursement of implants to be treated as a pass-through cost to be paid at invoice. Typically, the Plan enters into a Single Case Agreement for Implants. This does not raise the average hospital rate to more than $11,000 a day. The cost of the implant is added to the per-diem for that day and paid accordingly, which appears to raise the cost of the per-diem.*

Additionally, adjustments were made to some claims in error. The adjustments that were made in error, both over and underpayments were corrected. Fee schedule, pricing, policy and procedure changes have been implemented to correct workflow changes as they relate to implants, transplants and documentation for one-time agreements/contracts.

Rebuttal:
The reference to an average hospital rate of more than $11,000 per day does not involve an implant, but was an adjustment for a one time special agreement entered into with UAHC.

This overpayment was also calculated for the period May 2002 through December 2004. Refer to Attachment 1 for overpayment amounts.

B. Payment Accuracy

1. Physician Claims

a. Through TDCI's examination of UAHC, claims sampling indicated procedures were being paid fee for service when they actually fell under a capitation agreement. In order to determine the extent of this overpayment issue, all physician claims paid during the six months ended June 30, 2005 were reviewed. An eligibility file was obtained from UAHC, which included the eligibility history of all members and their assigned primary care physician ("PCP") back to 2001. The member's PCP was identified for the date of service paid. If the member was assigned to a capitated provider and the procedure paid was a capitated procedure, UAHC was questioned as to why the claims were paid fee for service. UAHC's policy regarding capitated procedures is as follows:

- If a member is assigned to a capitated provider, any other PCP in the same group will not be paid fee for service for any capitated procedure billed. (There is an exception for one particular provider who will be paid fee for service for EPSDT codes).

- If a member is assigned to a capitated provider and is seen by a PCP in a different capitated group, the provider will not be paid fee for service for any capitated procedure. (There is an exception for one particular provider who will be paid fee for service for EPSDT codes).

- A fee for service provider, whether non-participating, PCP, or specialist, can see a member who is assigned to a capitated group, and capitated procedures will be paid fee for service. A referral is not required.

Per Stephanie Dowell, CEO of UAHC, capitation arrangements are entered into as a contracting incentive and as a way to provide EPSDT services. Members cannot be kept from seeing a provider other than their assigned PCP.

UAHC Response:

Additionally, UAHC stated that FFS Provider's are not penalized for seeing and treating a member that is assigned to a capitated provider. There are many reasons why a member may see another provider; age, location, emergency, referral, etc. If a member goes into the local health department or FQHC, payment will not be withheld from this provider if EPSDT services are performed. Capitation of PCP is used as an incentive for access, quality improvement projects, EPSDT services, etc. But it is not viewed as an opportunity to penalize other Fee-For-Service providers for having treated the member.

As a result, the capitated claim lines that were paid to either the member's capitated group or to another capitated group were considered overpayments by UAHC. UAHC sent recoupment letters on September 15, 2005 to providers and is recouping $238,494.51 for the six months ended June 30, 2005. The explanation provided by UAHC and Vestica for the overpayments was that provider associations were not set up correctly in the claims processing system and that UAHC had been providing Vestica a PCP data file of only eligible members. Because current ineligible members were not on the data file, the capitated PCP information was not being used. For example, if a member became ineligible in May 2005, the member would have been excluded from the June 2005 data file yet claims could have been billed with dates of service 120 days prior. The capitated data would not be present and the claims would pay fee for service. UAHC has stated this problem has been corrected. In addition, Vestica had the understanding that if a member saw a PCP other than the member's assigned PCP, even in the same capitated group, the claims should pay fee for service.

UAHC has agreed to recoup payments for some capitated services when paid to a fee for service provider. These recoupments relate to providers who are billing as individual physicians but are also part of a capitated physician group. The amount to be recouped from these providers is $22,812.43 for the six months ended June 30, 2005.

See Attachment 1 for confirmed overpayments on capitated services for the period May 2002 through December 2004.

UAHC Response:
UAHC concurs with the auditor's findings. All overpayments are due to be recouped by December 15, 2005. Edits have been placed in the system to prevent payment of capitated services to any provider in the same group as the member's capitated PCP.

2. Facility Claims

a. Paid emergency room claims were compared to paid inpatient hospital claims to determine if an emergency room charge should not have been paid because it should have been included in the inpatient per diem. UAHC's policy is to not pay emergency room claims if the member was admitted to the same facility on the same day. UAHC has confirmed $33,050.35 was overpaid for the six months ended June 30, 2005 and will recoup the emergency room payments.

UAHC Response:
UAHC concurs with this finding. All overpayments ($33,050.35) have been recouped.

b. Well baby claims were reviewed because some of the claims billed with a revenue code of 170 or 171 were being denied as included in the mothers per diem or case rate but other claims to the same facilities were being paid. Sixty-four claims were paid during the six month period ended June 30, 2005. UAHC does not have well baby rates in their hospital contracts and has been paying adult medical-surgical and intensive care rates. UAHC responded that $21,654.80 of the claims should not have been paid but should have been included in the mother's rate. The remaining claims should have been paid because either 1) the baby was a dependent of a dependent (grandchild) and the mother was not eligible for TennCare or 2) the baby was a boarder baby because the stay exceeded the mother's hospital stay. The rate that should be paid for well baby claims needs to be considered by UAHC.

UAHC Response:
UAHC concurs with this finding. All overpayments ($21,654.80) have been recouped. A rate for well-baby stay has been established and claims are no longer priced at the Med/Surg rates for these services for contracted hospitals.

c. The number of days billed on inpatient facility claims was compared to the number of units paid in the claims processing system. The number of days was calculated based on the discharge date minus the admit date. If the bill type on the claim indicated the claim was a continuous

billing, the last day on the claim was considered a payable day. UAHC was asked to research the claims where the number of units paid exceeded the number of days billed on the claim.

UAHC has agreed $79,928.52 has been overpaid for the six months ended June 30, 2005. Some of the overpayments were due to the payment being based on the number of days authorized instead of the number of days billed. The dollar amount was correct on several of the claims UAHC researched yet the dates of service had been entered incorrectly in the claims processing system.

This overpayment was also calculated for the period May 2002 through December 2004. Refer to Attachment 1 for overpayment amounts.

UAHC Response:
UAHC concurs with the Statement. Procedural changes related to ER claims with inpatient stays in the same facility, cycle billing and outpatient services have been implemented. As a result of this audit, UAHC has established a well baby rate for all par and non-par providers.

C. Coordination of Benefits

1. Physician Claims

a. A sample of Explanation of Benefits ("EOBs") was requested for claims where a coordination of benefits ("COB") amount was included in the data file to determine if UAHC was correctly coordinating benefits. It was discovered that for claims where Medicare had paid on a claim and there was a deductible or coinsurance, UAHC was making overpayments.

Example:

Hospital bills $5,963.63 for an outpatient service. All of the charges are covered by Medicare. The coinsurance is $290.30 per the Medicare EOB. The Medicare payment to the provider is $563.97. Therefore, Medicare's total allowable is $854.27.

UAHC's allowable is 60% of billed charges, or $3,578.18. UAHC does not pay the difference between UAHC's allowable of $3,578.18 and Medicare's allowable of $854.27 which is $2,723.91. Instead, UAHC pays $3,014.21 which is the difference between UAHC's allowable of $3,578.18 and what Medicare paid, $563.97.

The overpayment in this example, at a minimum, is $290.30 which is the member's coinsurance.

Medicare deductibles and coinsurance are paid by the State for dual eligibles and are the responsibility of the member for the TennCare Standard enrollees.

The above example relates to facility claims, yet the situation applies to physician claims as well. All physician and facility claims with COB amounts were compared to the eligibility file provided by UAHC to determine if the members had Medicare. A listing of all potential overpayments related to Medicare coinsurance and deductibles was given to UAHC in order for EOBs to be pulled. The overpayments related to coinsurance and deductibles can only be determined by looking at each EOB individually. There were 2,238 EOBs to be reviewed for physician claims. As of the date of this report, an overpayment total has not been determined by Vestica and UAHC.

UAHC Response:
UAHC concurs with this finding. UAHC will continue to investigate the claims identified by the auditor to determine if the benefits were coordinated correctly and will recoup whatever funds were paid in error.

b. All physician and facility claims for which there was no coordination of benefits were compared against the eligibility file provided by UAHC to determine if claims were paid by UAHC and the member had Medicare coverage for the particular date of service. For physician claims, UAHC was asked to research Medicare eligibility on paid claims for five members in the amount of $12,173.19 to determine why the claims paid when the eligibility file indicated the member had Medicare coverage. For the six months ended June 30, 2005, $1,455.69 will be recouped. Additional paid amounts of $537,115.32 for the six months ended June 30, 2005 are being reviewed by UAHC to determine if the claims should have been billed to Medicare.

UAHC Response:
UAHC concurs with this statement.

2. Facility Claims

a. As stated above, UAHC was not coordinating Medicare benefits correctly for physician and facility claims. A listing of all potential overpayments related to Medicare coinsurance and deductibles on facility claims was also given to UAHC in order for EOBs to be pulled.

There were 1,433 EOBs to be reviewed for facility claims. As of the date of this report, an overpayment total has not been determined by Vestica and UAHC.

b. For facility claims, UAHC was asked to research Medicare eligibility on paid claims in the amount of $538,969.72 to determine why the claims paid when the eligibility file indicated the member had Medicare coverage. For the six months ended June 30, 2005, $18,889.21 will be recouped. In some cases, UAHC stated Medicare eligibility information was not received until after the claim processed. Medicare benefits had been exhausted for the larger claims. UAHC will recoup even if the Medicare eligibility was not available when the claims processed.

UAHC Response:
UAHC concurs with this statement.

c. UAHC researched claims paid for 20 members for which the eligibility file indicated the member had commercial coverage for the dates of service paid by UAHC. UAHC agreed $163,441.99 should be recouped of the $454,169.95 that was paid for these members. An additional $279,983 in paid claims with potential commercial coverage is being reviewed by UAHC for the six months ended June 30, 2005. UAHC's staff researches other insurance coverage regularly per Stephanie Dowell. These confirmed overpayments will be reviewed by UAHC to determine why the overpayments were not identified internally.

UAHC Response:
UAHC concurs with this statement.

D. Eligibility

1. Physician Claims

a. All physician and facility claims were compared to the eligibility file provided by UAHC to determine if the members were eligible for TennCare for the dates of service paid. Approximately $15,835 for the six months ended June 30, 2005 was identified in physician claims as the member not being eligible for the date of service paid, yet UAHC responded the claims paid in accordance with eligibility that was in the claims processing system at the time the claim was adjudicated. UAHC does not intend to recoup payments to providers where eligibility was removed retroactively. UAHC has agreed to recoup

$1,591.41 for claims that paid incorrectly based on eligibility information that was available when the claims processed.

UAHC Response:
UAHC concurs with this statement.

2. Facility Claims

a. Overpayments identified in the facility claims due to lack of TennCare eligibility were largely attributable to the member being eligible for a portion of an inpatient stay but not for the entire date span billed. UAHC has agreed to recoup $124,721.92 for payment of ineligible days on facility claims for the six months ended June 30, 2005.

UAHC Response:
UAHC concurs with this statement. Identified funds have been recouped. As discussed during the audit, timing will continue to be an issue related to files received from the State and claims payment schedules. Procedural changes related to eligibility terms during a hospital admission have been implemented.

E. Duplicates

1. Physician Claims

a. Duplicate physician claims were identified within the 2005 data by identifying multiple claims that were paid with the same social security number and the same date of service. UAHC responded $146,362.45 should be recouped for the six months ended June 30, 2005. Over one half of the claims identified as duplicates were lab and radiology claims. Vestica stated the duplicate logic in the claims processing system was not applied to lab or radiology claims until August 2005. UAHC stated on October 14, 2005, the file with these recoupments will be reviewed again, and the recoupment amount will probably decrease. UAHC realized some of the procedures that appeared as duplicates were actually not because the same service was in fact provided twice in the same day (i.e. a member saw two different specialty physicians for evaluation and management)**.**

UAHC Response:
*UAHC concurs with this statement. Procedural changes related to denial of laboratory and radiology services performed in the same day have been implemented**.***

2. Facility Claims

a. Duplicate inpatient claims were identified within the 2005 data by identifying multiple claims that were paid with the same social security number and admission date. There were instances where the same claim had been paid to two different providers because an incorrect provider was manually chosen when the claim was processed. UAHC agreed $232,674.96 were duplicate payments for the six months ended June 30, 2005 and will recoup these monies.

   This overpayment was also calculated for the period May 2002 through December 2004. Refer to Attachment 1 for overpayment amounts.

b. UAHC's policy is to pay for only the level of care that was authorized for inpatient services. If a hospital bills for two days of intensive care yet UAHC had authorized two medical/surgical days, then UAHC will pay for two days at the medical/surgical rate. In order to pay at a rate lower than what was billed, Vestica has been adding revenue code 191 to the claim which is Subacute Care- Level 1 (skilled care). The authorized level of care payment is then made on this revenue code line. This procedure does not provide data that is reflective of the actual services provided. TDCI had questioned the reporting of the 191 revenue code for encounter data purposes. UAHC has contacted TennCare Bureau officials about the practice of adding the 191 revenue code and, subsequently, UAHC has altered their policies. Also, in several cases, payment has been made for twice the number of days billed because the payment was inadvertently made on the higher level of care billed *and* on the revenue code 191 Vestica has added in the system. Overpayments were identified on claims where the number of days paid was double the number of days billed. UAHC has agreed $38,131 was paid in error due to this reason for the six months ended June 30, 2005.

   This overpayment was also calculated for the period May 2002 through December 2004. Refer to Attachment 1 for overpayment amounts.

c. Duplicate payments were also identified when the admission date differed on two separate claims, and the dates billed fell within the date span of another hospital claim that had been billed. Most of these overpayments were due to the fact hospitals submitted interim bills and then later submitted a bill for the entire hospital stay. UAHC has agreed to recoup $549,486.48 in duplicate payments due to this reason for the six months ended June 30, 2005.

This overpayment was also calculated for the period May 2002 through December 2004. Refer to Attachment 1 for overpayment amounts.

d. Duplicate payments for emergency room claims were paid in the amount of $19,339.11 for the six months ended June 30, 2005. These also were identified by payments for the same member, date of service, and procedure on two separate claims. These claims were not for two trips to the emergency room in the same day.

e. Outpatient duplicate payments were made in the amount of $22,371.07 for the six months ended June 30, 2005. Again, these were identified by payments on two separate claims for the same member, date of service, and procedure.

UAHC Response:
UAHC concurs with this statement.

F. Timeliness

1. Physician Claims

a. Only dates of service January and February of 2005 were tested for timeliness because the end of the timely filing deadline of 120 days for dates of service March through June 2005 would have been beyond the paid dates being reviewed. The number of days it took a provider to submit a claim was calculated by subtracting the ending date of service on a claim from the receive date in the claims processing system. Claims paid with a receive date over 120 days were submitted to UAHC to review to explain why the claims were paid when they exceeded the timely filing limit. UAHC responded either 1) the claims were submitted within 120 days of another carrier's EOB, 2) the claim had been resubmitted with a correct code, or 3) the payment was due to an appeal. UAHC agreed only $185.88 should not have been paid on the claims reviewed. Because of the time required to research these claims and because of the immaterial dollar amount, the timeliness testing was not expanded.

UAHC Response:
UAHC concurs with this statement.

2. Facility Claims

a. Facility claims paid in April 2005 that were received more than 120 days from the date of discharge were reviewed by UAHC. UAHC's research revealed $5,501.50 was paid when the claims were not filed

in accordance with UAHC's timely provisions. Research revealed most of the claims were paid correctly due to the fact the provider had filed with another insurance carrier first or the claim was a resubmitted claim.

UAHC Response:
UAHC concurs with this statement.

I acknowledge the courtesy and cooperation of the officers and employees and UAHC and Vestica during this claim review.

Please let me know if you have any questions regarding the information provided in this report.

UAHC FINAL COMMENTS:

UAHC Health Plan, Inc. accepts the agreed upon findings of this audit and the professional and courteous manner in which it was conducted. Although we may not concur on all findings, the audit was deemed to be fair and impartial. UAHC will continue to research and audit files identified by the auditor that were not fully researched and or completed. Identified recoupments, adjustments etc. will be performed upon confirmed research of the outstanding claims.

UAHC does not concur with the final amount of overpaid claims to be recouped as submitted by the auditor. UAHC's findings were in-line and closer to the amounts originally reported by the auditor and submitted to the Plan.

UAHC has put processes in place to prevent and or identify errors for future claims processing. The audit has enlightened the Plan with regards to quality improvements needed in its claims processing procedures and oversight necessary for its third party claims vendor/subcontractor. Identified controls have been established and processes implemented.

UAHC has recouped 57% of the overpayments identified in the audit and will continue to recover all identified overpayments and errors. UAHC's goal is to recoup 95% of the identified overpayments by December 15, 2005. The Plan's Network remains strong and committed to the completion of the audit and has worked with us in recouping these funds timely.